

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5501	
BIRTH NO.				2	
1. NAME OF DECEASED (Type or Print) BAIDWTN, Maude				2. DATE AND HOUR OF DEATH May 31, 1969 3:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 6-03	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing & Convalescent Ctr.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-17-85 9. AGE (In years last birthday) 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Daniel Shaw		14. MOTHER'S MAIDEN NAME Sarah Shaw		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-54-3825J1		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ante coronary occlusion				minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) arteriosclerosis years	
				(C) chronic brain syndrome years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/17 19 68 to 5/31 19 69 , that (I) (we) last saw the deceased alive on 5/31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ae Martin				23B. DATE SIGNED 5/31/69	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MAECHT MD				23D. ADDRESS 2 E. Pearl St Baltimore 21202	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE June 1/69		24C. NAME OF CEMETERY or CREMATORY Greenmount A. Home	
24D. LOCATION (City, town, or county) Baltimore		24E. LOCATION (State) Md		25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969	
25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Philip Herwig Sons		ADDRESS 21202	

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BALTIMORE CITY HEALTH DEPARTMENT				69 5502	
CERTIFICATE OF DEATH				REG. NO. 69 5502	
BIRTH NO. <i>69 5502</i>		NAME OF DECEASED <i>CATHERINE DORSEY POWELL</i>			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH <i>31 MAY 69 11:05 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>MARYLAND</i>		B. COUNTY <i>15-04</i>	
<i>33</i> THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>2300 W. NORTH AVE</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-1-15</i>	9. AGE (in years last birthday) <i>53</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>nursing</i>		<i>nursing</i>		<i>Waynesboro PA</i>	
13. FATHER'S NAME <i>GEORGE POWELL</i>		14. MOTHER'S MARDEN NAME <i>ELLA PATRICK</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>21420-558</i>		17. INFORMANT <i>James B. Bogan</i> ADDRESS <i>1607 Bridge Street</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>410.94174X</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <i>MYOCARDIAL INFARCTION</i>		<i>10 HOURS</i>	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>METASTATIC CARCINOMA BREAST 1963</i>	
19A. DATE OF OPERATION <i>30 MAY 69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>PARAPLEGIA</i>		20A. AUTOPSY (Yes or No) <i>N/D</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>30 MAY 19 69</i> to <i>31 MAY 19 69</i> that (I) (we) last saw the deceased alive on <i>31 MAY 19 69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Merwyn Bagan</i>				23B. DATE SIGNED <i>31 May 69</i>	
23C. PHYSICIAN'S NAME (Type) <i>MERWYN BAGAN M.D.</i>				23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>6.5.69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Green Hill Cemetery</i>	
<i>Burial</i>				<i>Waynesboro PA</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 2 1969</i>		25B. NAME OF REGISTRAR <i>James E. Taylor, R.D.</i>		25C. FUNERAL DIRECTOR <i>Alvin L. McQuinn</i> ADDRESS <i>2302 W. North Ave</i>	




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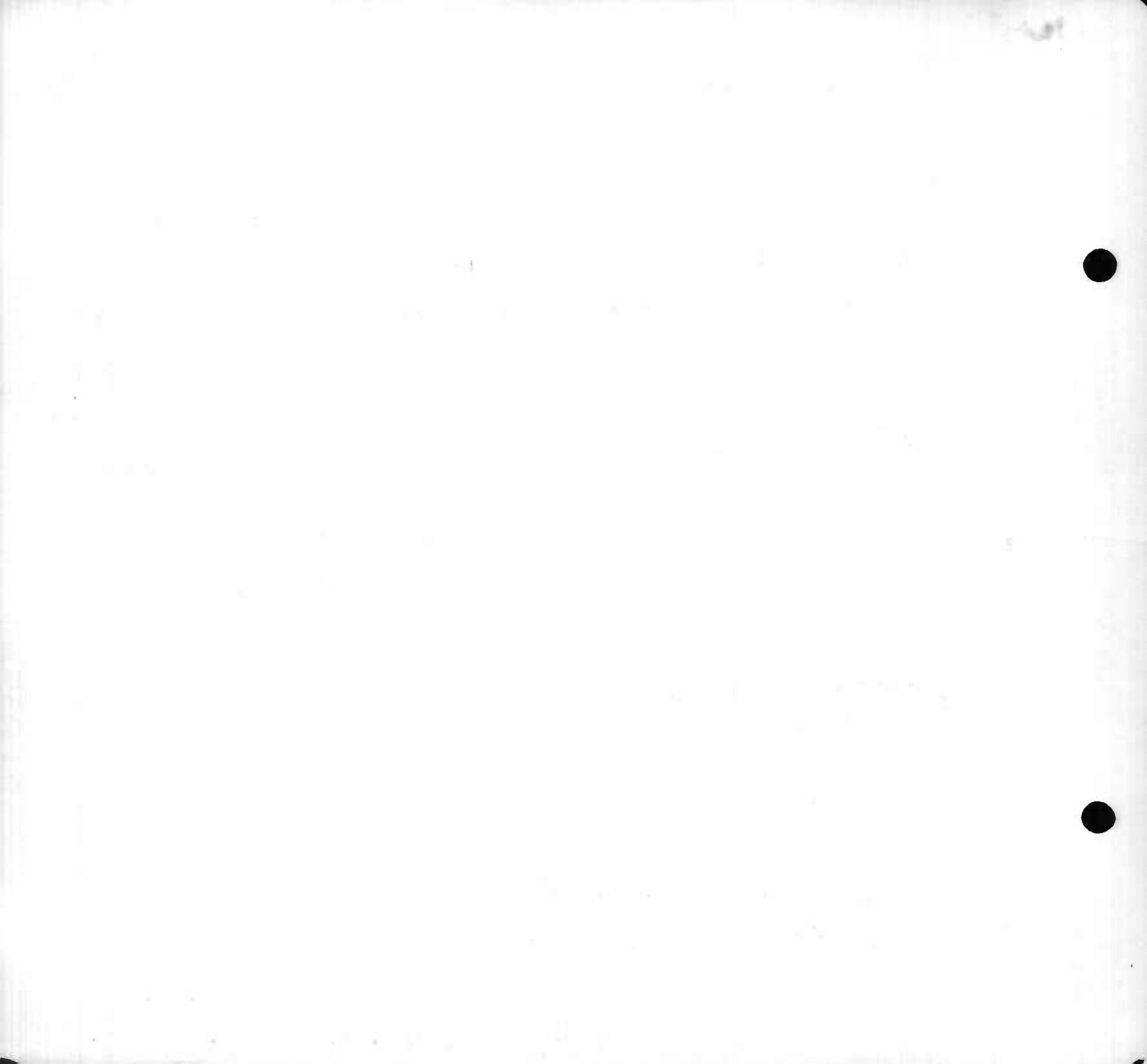
69 5503

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 5503

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GILBERT JOHNSON		2. DATE AND HOUR OF DEATH 5-29-69 9⁰³ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 27-16	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTO.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BEZUEDE + GREENSPRING AVES.		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3213 WOODLAND AVE		5. SEX M 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6-5-29 9. AGE (in years last birthday) 39	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker		10B. KIND OF BUSINESS OR INDUSTRY Consolidate Engineer		11. BIRTHPLACE (State or foreign country) Va 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Johnson				14. MOTHER'S MAIDEN NAME Mary Fisher	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 223-32-6465		17. INFORMANT Mr Chatman Johnson 201 Blue Jay Lane N.J.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hepatorenal Syndrome		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Surgery - gastrectomy; anastomosis of common bile duct, hepatic artery + closure of portal vein		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 5-17-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED g.i. bleeder		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indify medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5-18 19 69 to 5-29 19 69 that (1) (we) last saw the deceased alive on 5-23 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 5/29/69	
23C. PHYSICIAN'S NAME (Type) STEPHEN D. ROSENBAUM		23D. ADDRESS SINAI HOSPITAL OF BALTO			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/2/69		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore, CO. MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969			
25B. NAME OF REGISTRAR Robert E. Tabor, MD		25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave.			



FUNERAL DIRECTOR: IMPORTANT

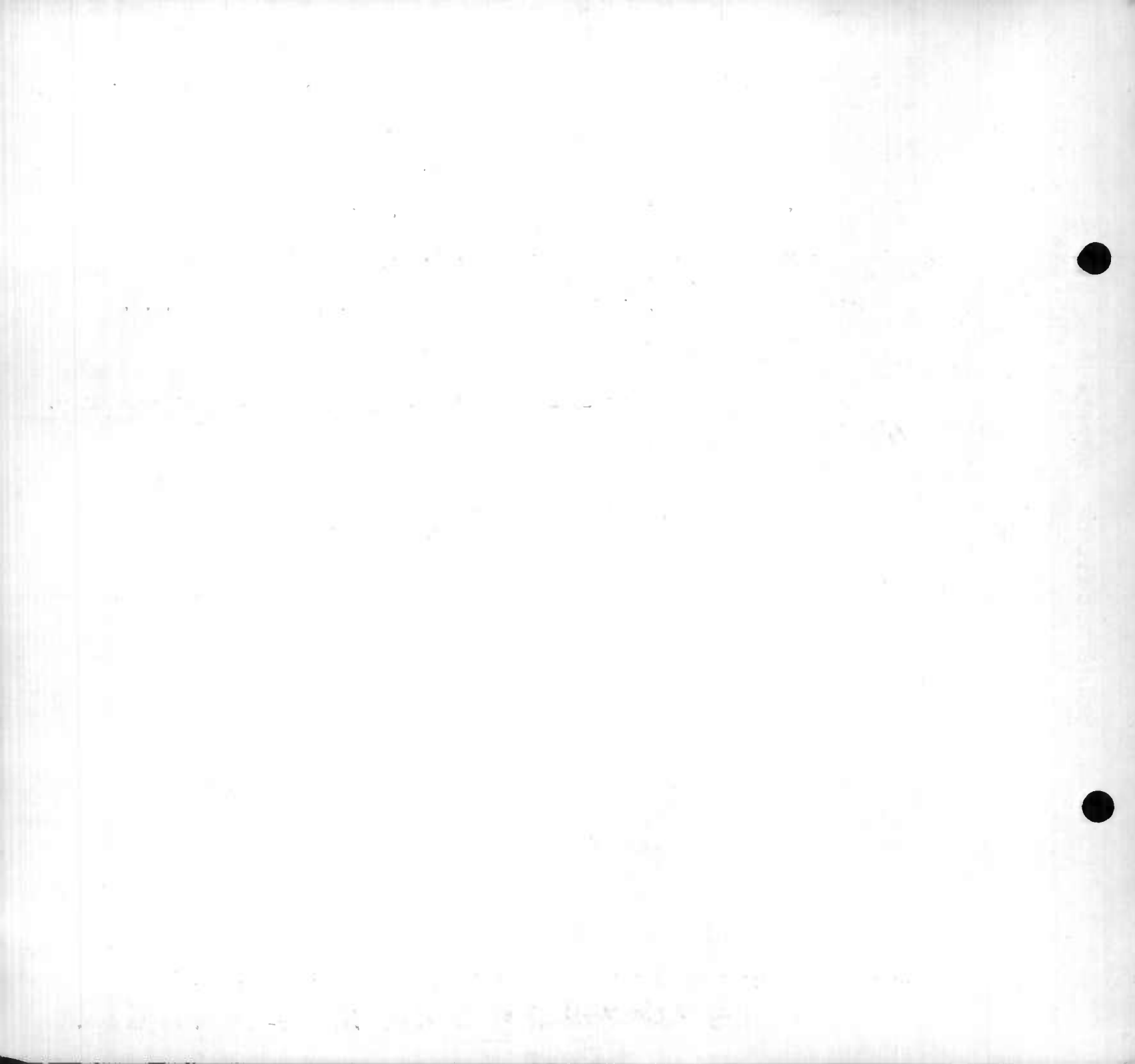
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BALTIMORE CITY HEALTH DEPARTMENT

69 5504 CERTIFICATE OF DEATH

REG. NO. 69 5504

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Rosetta Sample		2. DATE AND HOUR OF DEATH May 27, 1969 6:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 908 N. Carey Street			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 16-02		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 908 N. Carey Street		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1899	9. AGE (In years lost birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jeter Murray			
14. MOTHER'S MAIDEN NAME Mariah Paraway				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 219-20-6542		17. INFORMANT ADDRESS Miss Charlotte Murray-1111 Wildwood Pkwy.			
18. 1899 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Uremia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Renal Carcinoma			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from August 1963 to MAY 27 1969 , that (1) (we) last saw the deceased alive on MAY 26 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel R. Owings, Jr., M.D.				23B. DATE SIGNED May 28, 1969	
23C. PHYSICIAN'S NAME (Type) SAMUEL R. OWINGS, JR., M.D.				23D. ADDRESS 909-11 N. Carey St. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31/1969		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969			
25B. NAME OF REGISTRAR Robert E. Hall, M.D.		25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.			

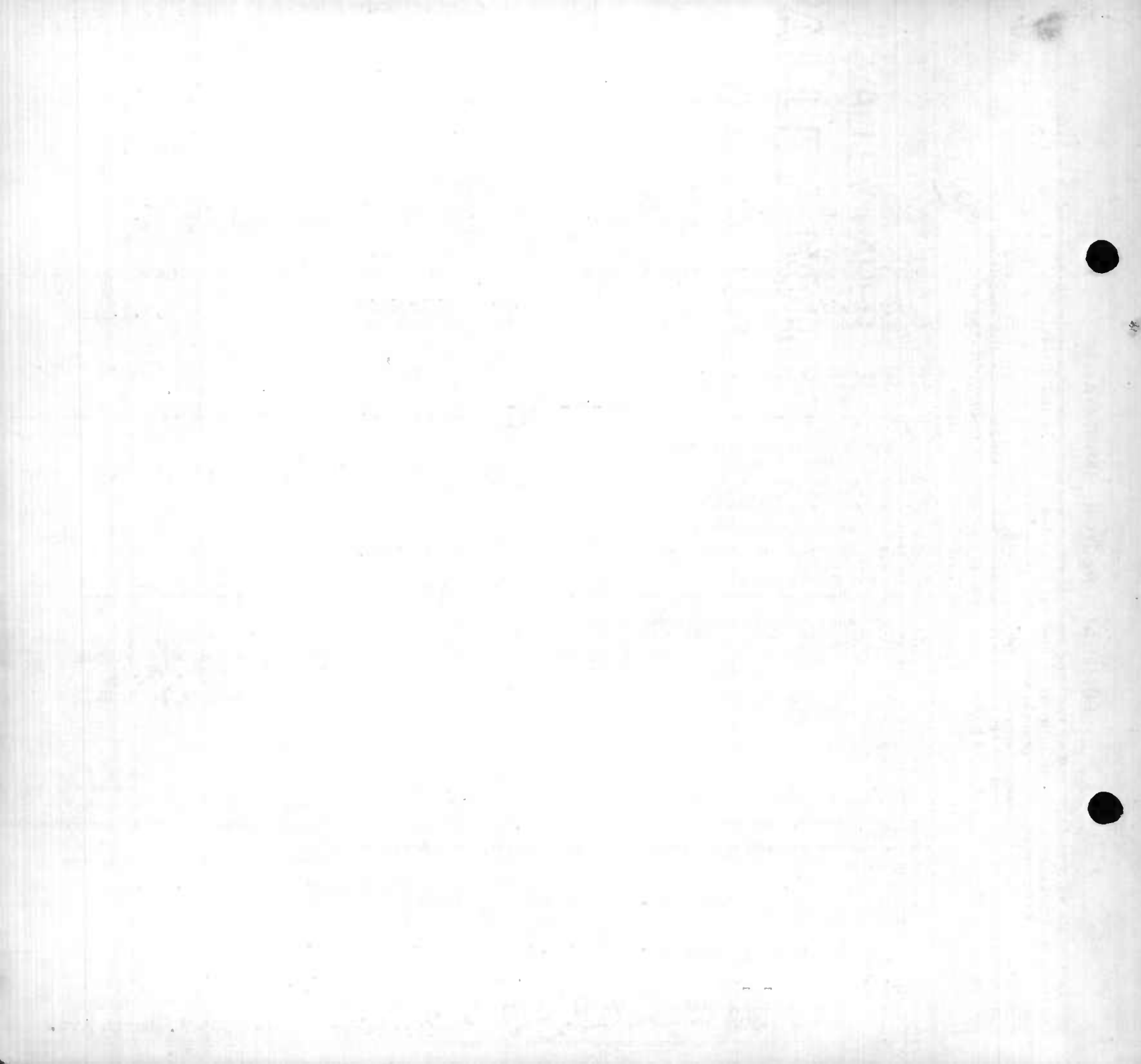


CERTIFICATE OF DEATH

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BERTHA B. ROBINSON		5/28/69 18 30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND	
31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE, MD. 21224				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2414 McCulloh ST. BALTIMORE, MD. 21217	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11-1-80	88	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
				DISTRICT OF VIRGINIA	U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
??			BROWN, ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		264-09-4918-B		4940 EASTERN AVE. BCH RECORDS: BALTIMORE, MARYLAND 21224	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/31 1968 to 5/28 1969, that (I) (we) last saw the deceased alive on 5/28 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
V. Valdmanis, MD OEGRE				5/28/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
V. VALDMANIS MD.				BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE, MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	6-2-69	Arbutus Memorial Park		Baltimore County Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 2 1969		Robert E. Taylor, M.D.		Nutter Funeral Home 3035 W. North Ave.	

FUNERAL DIRECTOR: IMPORTANT

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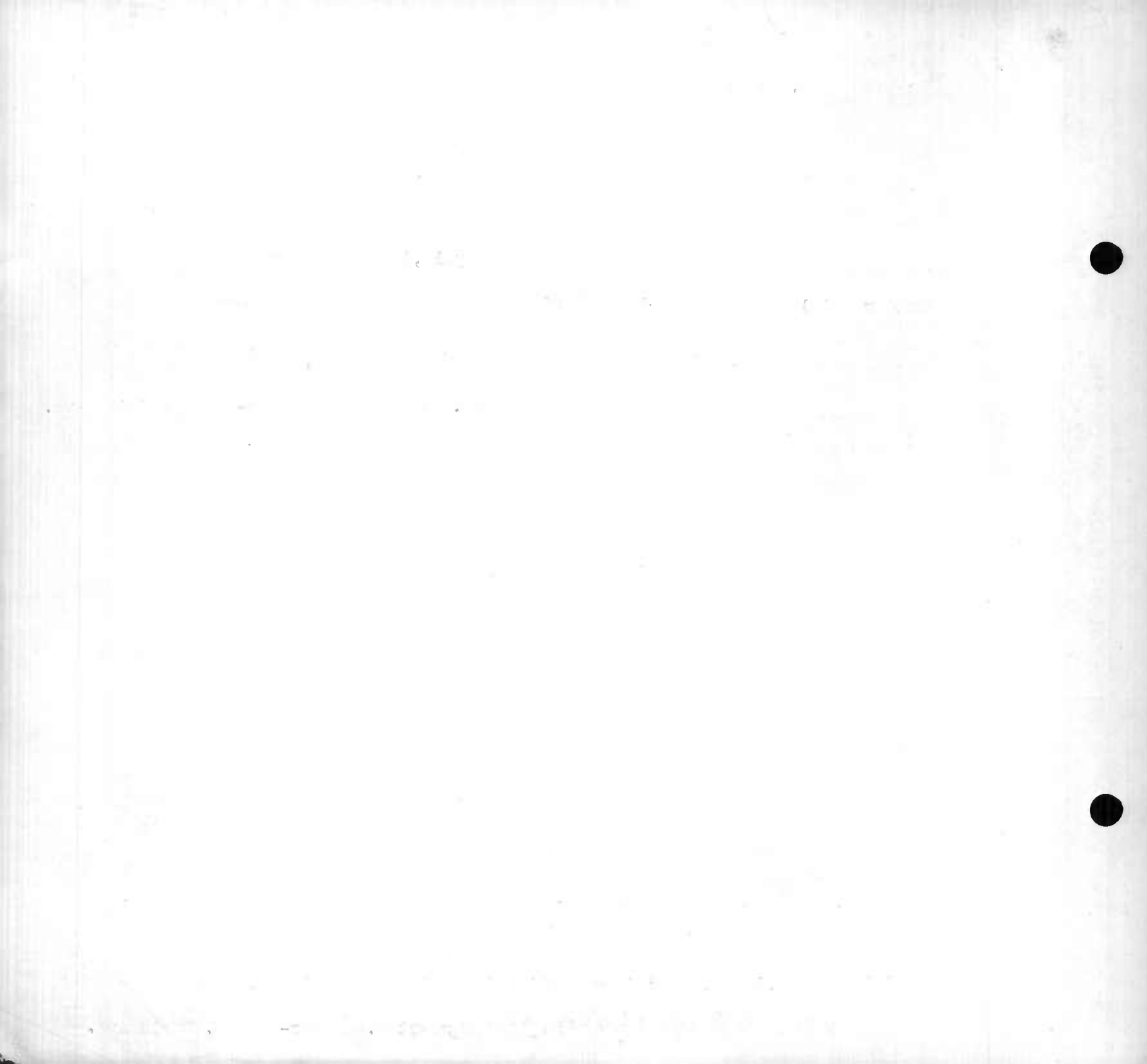


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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5506

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MAISEL O. GASKINS		2. DATE AND HOUR OF DEATH 5-26-69 1 6:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE		17-02	
FULL NAME OF HOSPITAL OR INSTITUTION MD. GEN. HOSP.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 111 TIFFANY CT					
5. SEX F	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1902	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Counter Girl		10B. KIND OF BUSINESS OR INDUSTRY School Cafeteria		11. BIRTHPLACE (State or foreign country) VIRGINIA, Danville	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES HUDSON			
14. MOTHER'S MAIDEN NAME NEWSOM, Mable		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Paulette Alexander-2015 Braddish Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CARCINOMA PANCREAS-		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-24 19 62 to 5-26 19 69 , that (I) (we) lost the deceased alive on 5-25 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel H. White MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-26-69	
23C. PHYSICIAN'S NAME (Type) DANIEL H. WHITE MD		23D. ADDRESS MD. GEN HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5/31/1969	24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Nutter		25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5507

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROLLIND HAMMETT

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
5 30 69 5:12 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

South Balto. General Hospital D.O.A.

3. DATE PRONOUNCED DEAD Month Day Year Hour
May 30 1969 5:12 p.m.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

10-02

6. SEX

Male

7. RACE

Colored

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

2-7-41

10. AGE (In years)

28

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2609 W. Fayette St.

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Berdie Hammett

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Pence Worker

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Florine Flood

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

247-8404311

18. INFORMANT

Deloris Hammett 2609 W. Fayette St.

ADDRESS

19. E 815.1

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Cerebrospinal injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Frankfurt Ave. 1580' S. of 2nd St.

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

5 30 69 4:40

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger in auto-fixed object coll.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 31, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-5-69

24C. NAME of CEMETERY or CREMATORY

Mt. Zion

24D. LOCATION (City, town, or county) (State)

Manning, South Carolina

25A. DATE REC'D BY HEALTH DEPT.

JUN 2 1969

25B. NAME OF REGISTRAR

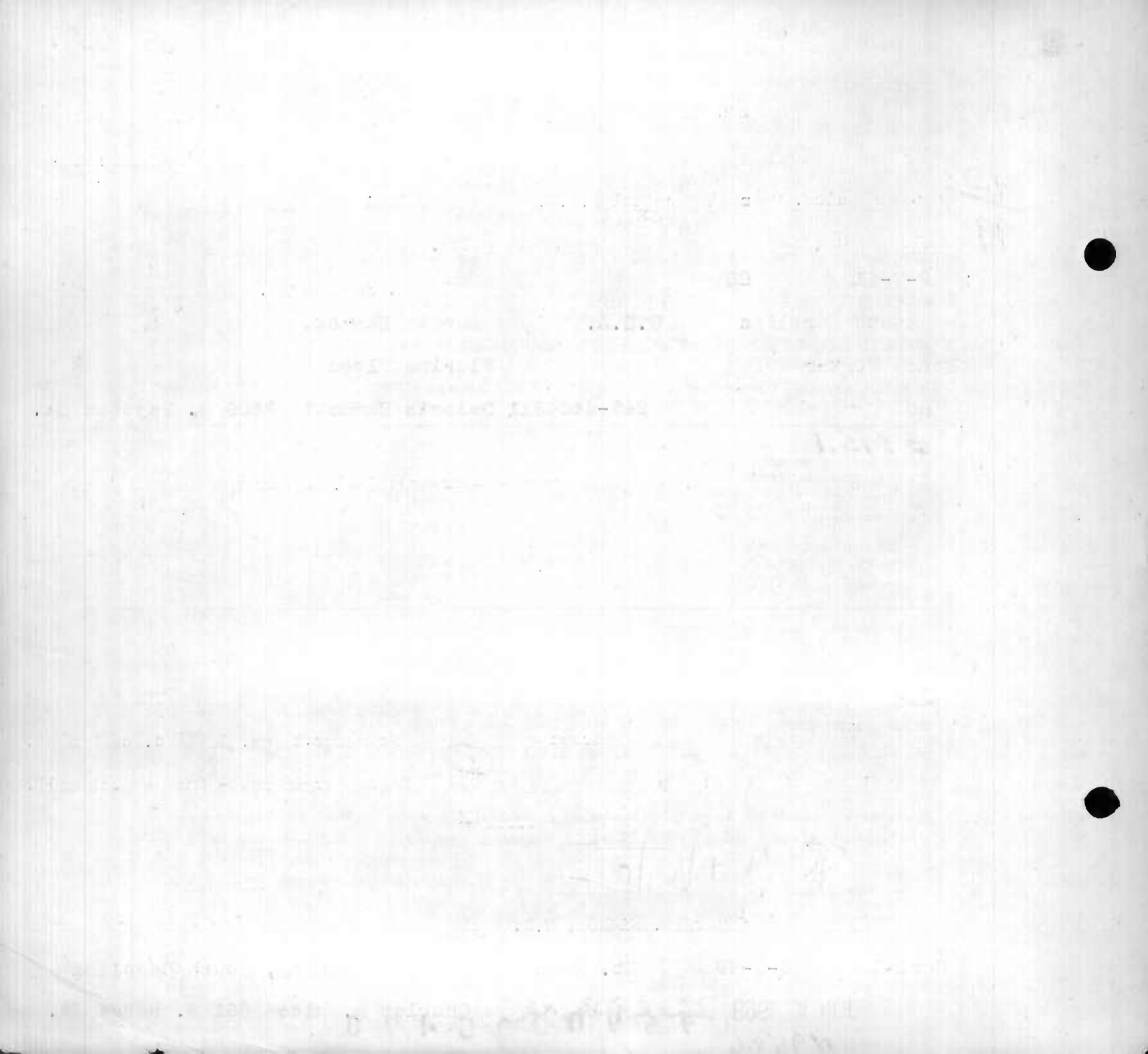
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Charles A. Rice

ADDRESS

661 W. Barre St.



1
m-235

69 5508 BALTIMORE CITY HEALTH DEPARTMENT

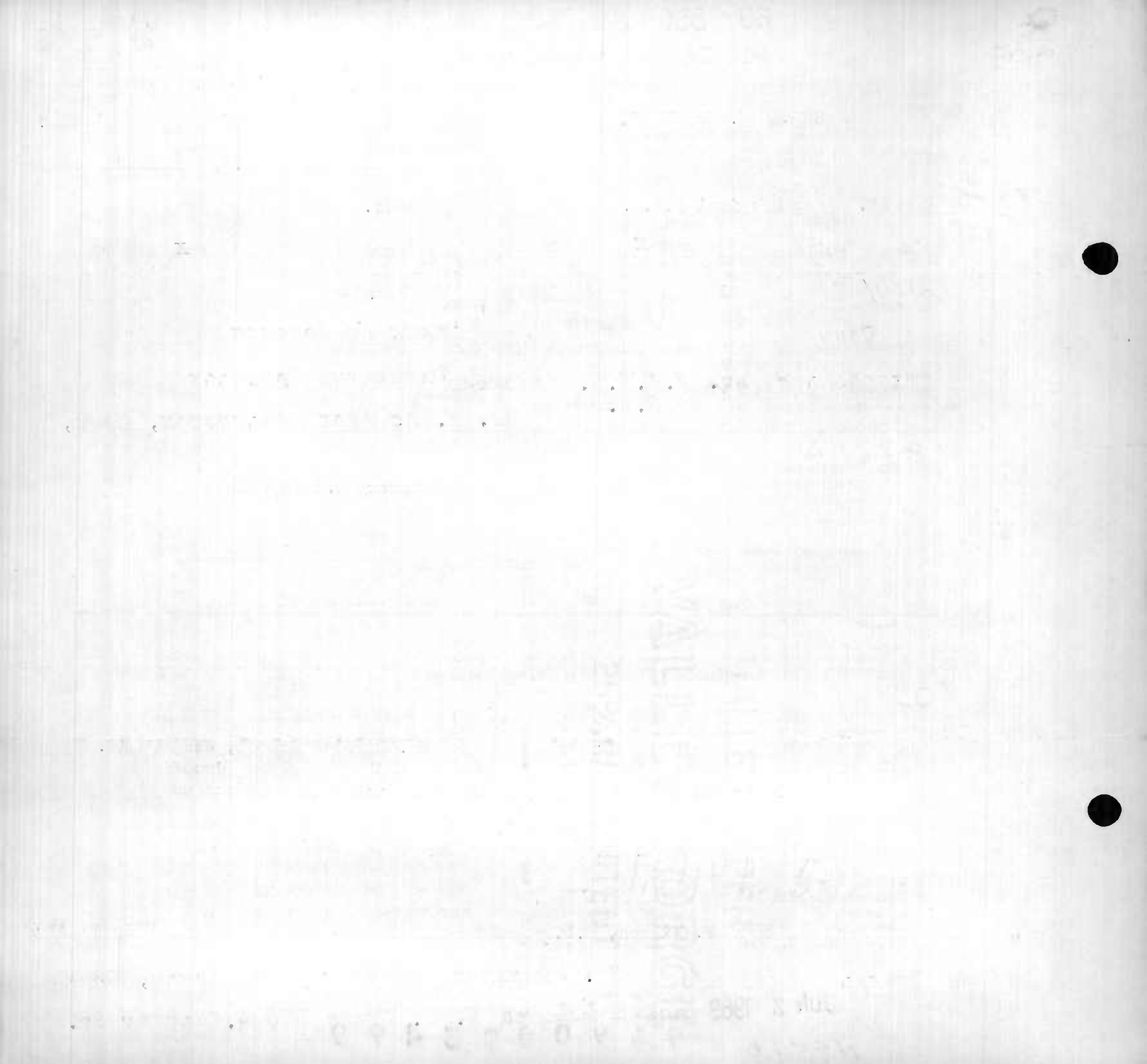
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5508

REG. NO.

BIRTH NO.

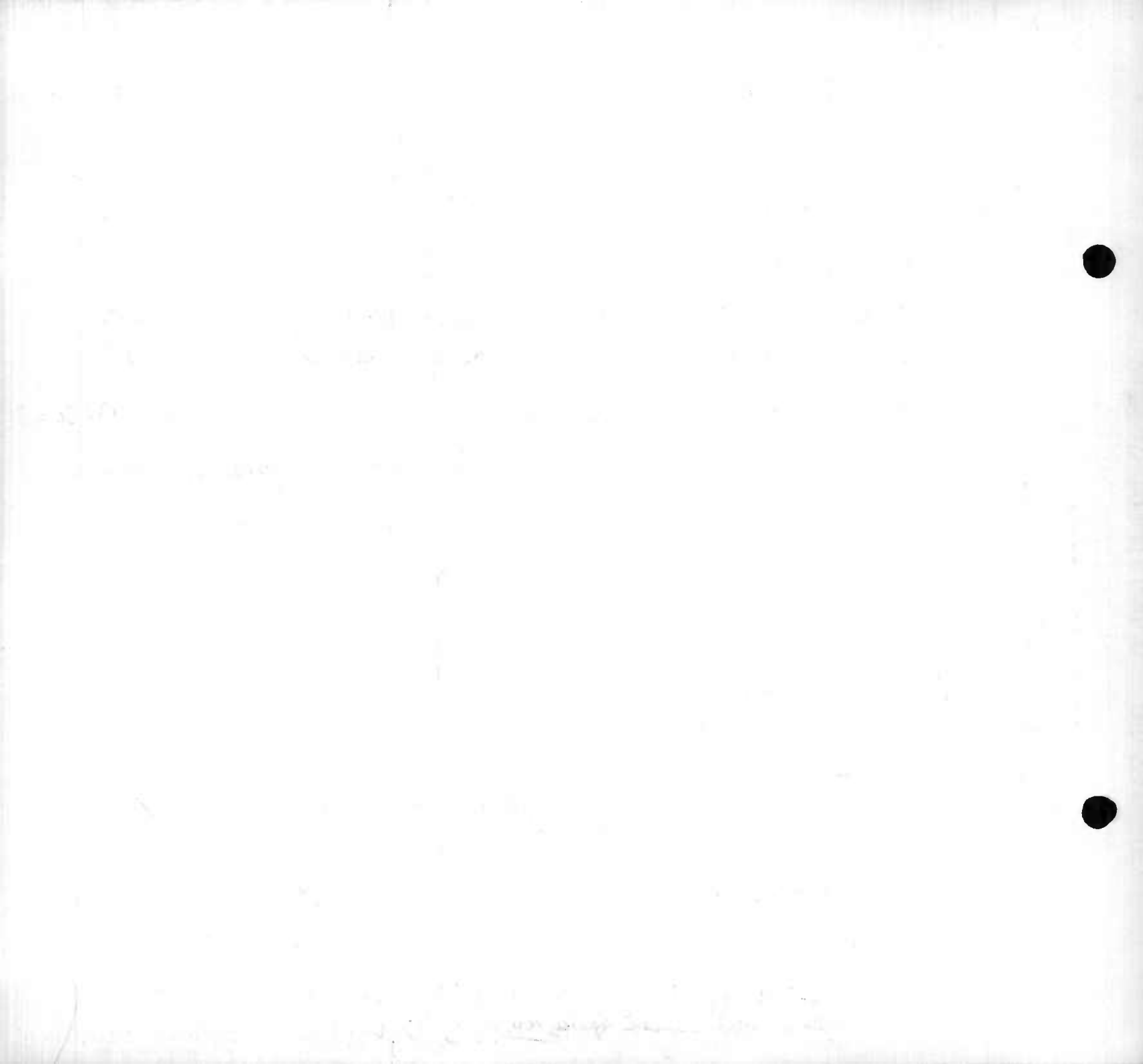
1. NAME OF DECEASED (Type or Print) EDWARD M. McDONOUGH				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 5 27 69 4:45 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital D.O.A.				3. DATE PRONOUNCED DEAD Month Day Year Hour May 27, 1969 4:45 p.m.			
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 8/30/87				10. AGE (In years last birthday) 81		11. BIRTHPLACE (State or foreign country) CONN	
12. CITIZEN OF WHAT COUNTRY? US				13. FATHER'S NAME FRANK MC DONOUGH		14. MOTHER'S MAIDEN NAME CATHERINE DONNELLY	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ELEC. ENG. N.Y.N.H. HARTFORD				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) R. SECURITY NO.			
17. SOCIAL SECURITY NO. R. SECURITY NO.				18. INFORMANT J. E. Mc Avoy ARLINGTON, MASS.			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E880 X1				CAUSE OF DEATH (A) IMMEDIATE CAUSE Craniocerebral injuries DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____			
20. DATE OF OPERATION 2				21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) School			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Mt. DeSales School, Academy Rd. & Woodfield				22D. TIME OF INJURY (APPROX.) Month Day Year Hour Minute 5 27 69 4:25 p.m.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Subject fell down stairs			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED May 28, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 5/31/69			
24C. NAME OF CEMETERY OR CREMATORY ST. BERNARDS CEMETERY				24D. LOCATION (City, town, or county) (State) NEW HAVEN, CONN			
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969				25B. NAME OF REGISTRAR W. E. Taylor, M.D.			
25C. FUNERAL DIRECTOR H. W. MEARS				25D. ADDRESS 805 N. CALVERT ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 5509				Baltimore City Health Department		CERTIFICATE OF DEATH		REG. NO. 69 5509	
1. NAME OF DECEASED (Type or Print) MILLIGAN, Larry Richard				2. DATE AND HOUR OF DEATH 5/29/69 2:20 A. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Delaware B. COUNTY V-07					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital				C. CITY OR TOWN Seaford			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX Male				6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/20/51	
9. AGE (in years last birthday) 17				10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT				10B. KIND OF BUSINESS OR INDUSTRY SEAFORD HIGH SCHOOL		13. FATHER'S NAME Donald Milligan			
14. MOTHER'S MAIDEN NAME Delores Comstock MILLIGAN				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 221-76-6423		17. INFORMANT ADDRESS DONALD R. MILLIGAN - SEAFORD, DEL.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) 238.1 I Brain stem compression				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prob. Brain stem tumor.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) DUE TO, OR AS A CONSEQUENCE OF: (?)					
(C) _____									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Obstructive hydrocephalus									
19A. DATE OF OPERATION 5-28-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive hydrocephalus		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -					
21D. TIME OF INJURY (APPROX.) 6		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -					
22. I certify that (I) (this hospital) attended the deceased from May 27th 19 69 to May 28th 19 69 that (I) (we) last saw the deceased alive on May 28th 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE F. Velasco				23B. DATE SIGNED 5-29-69				23C. PHYSICIAN'S NAME (Type) Frankisco Velasco	
23D. ADDRESS The Johns Hopkins Hospital				24. NAME OF CEMETERY OR CREMATORY GOOD FELLOWS CEMETERY					
24A. BURIAL CREATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 1 1969		24C. LOCATION (City, town, or county) (State) SEAFORD, DELAWARE		25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969			
25B. NAME OF REGISTRAR Wm. E. Gabe, M.D.		25C. FUNERAL DIRECTOR Wm. E. Gabe, M.D.		25D. ADDRESS Seaford, Delaware					

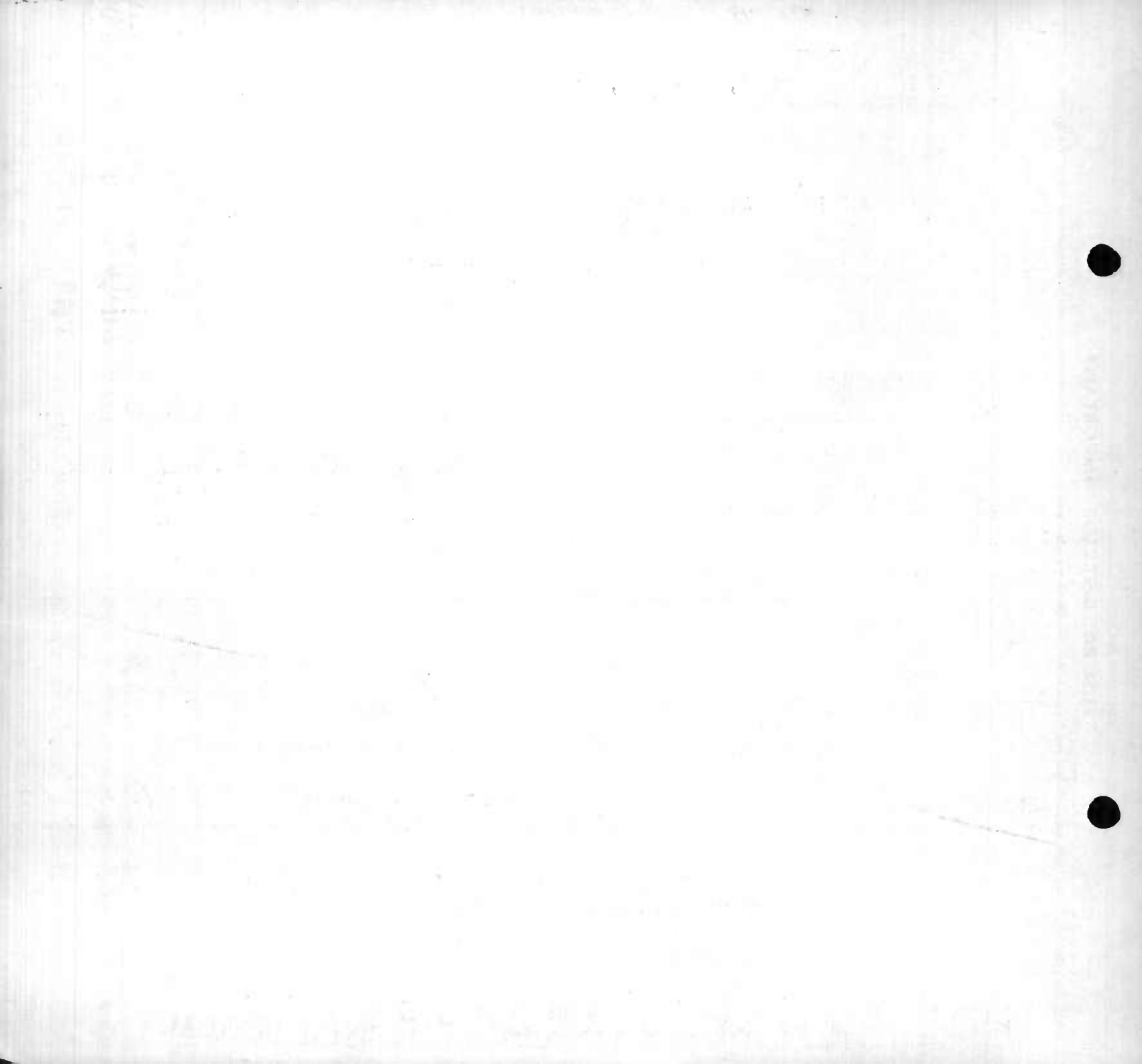


54-27-65 djs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

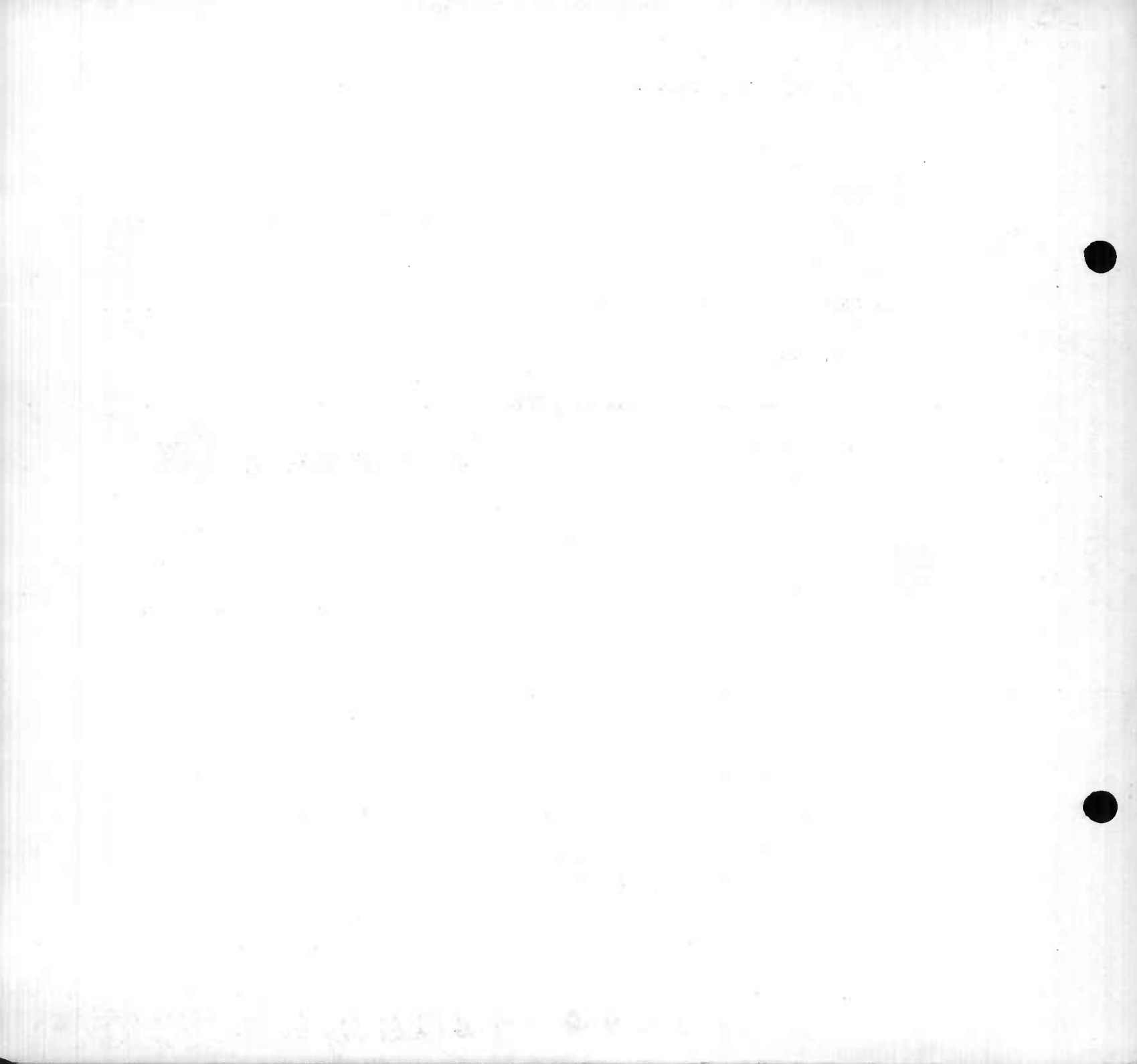
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5510	
BIRTH NO. 54-27-65		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Wright, Baby Girl, Joyce		2. DATE AND HOUR OF DEATH May 22, 1969 9 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 21224 4940 Eastern Avenue Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 1521 BETHEL STREET 21213 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-69	9. AGE (In years last birthday) 7	If Under 1 Yr. Months Days 7 45
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Failure, Acidosis Immaturity (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/22/69 1:00 PM to 5/22 (9 PM) 1969, that (I) (we) last saw the deceased alive on 5/22 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DAE UN KIM		23B. DATE SIGNED 5/23/69		23C. PHYSICIAN'S NAME (Type) DAE UN KIM	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 5-26-69		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CITY HOSPITALS	
24D. LOCATION (City, town, or county) (State) 4940 EASTERN AVE. BALTO. MD. 21224		24E. FUNERAL DIRECTOR HOSPITAL DISPOSAL		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR J. E. Barber, M.D.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HUDSON G. ASHLEY		2. DATE AND HOUR OF DEATH 5/29/69 640 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2-01	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 10 SOUTH CHESTER STREET 21231					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-00	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Painter		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME THOMAS S. Ashley				14. MOTHER'S MAIDEN NAME ANNA ADAMS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-01-7306		17. INFORMANT ADDRESS BCH: RECORDS 4940 EASTERN AVE. BALTO. MD. 21224	
18. 250.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE CHOCLE CHOCO (X) DUE TO, OR AS A CONSEQUENCE OF: (B) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/29 19 69 to 5/29 19 69 , that (I) (we) last saw the deceased alive on 5/29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth E Fligsten MD OEGREE				23B. DATE SIGNED 5/29/69	
23C. PHYSICIAN'S NAME (Type) KENNETH FLIGSTEN M.D. OEGREE				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO. MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-31-69		24C. NAME OF CEMETERY or CREMATORY MT. CARMEL CEM.	
24D. LOCATION 5702 O'DONNELL ST. BALTO., MD.		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR John E. Talley, M.D.		25C. FUNERAL DIRECTOR John E. Talley, M.D.	
ADDRESS 9015 CONKLING ST. BALTO., MD. 21224					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5512

BIRTH NO.		1. NAME OF DECEASED (Type or Print) TINY T. JEUNETTE		2. DATE AND HOUR OF DEATH 5/29/69 12:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-78		5. STREET AND NUMBER 5542 Lothian Rd.	
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hosp.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/2/95	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Naval gun factory		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME John Jeunette		14. MOTHER'S MAIDEN NAME Lillie Colognin		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 014434		17. INFORMANT Medical record	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CVA with coma DUE TO, OR AS A CONSEQUENCE OF: and aspiration pneumonia (B) _____ DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 5-28-69 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CAUSE OF DEATH 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-6-1969 to 5-29-1969 that (I) (we) last saw the deceased alive on 5-28-1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ching-Hui Tsai, M.D.		23B. DATE SIGNED 5-29-69		23C. PHYSICIAN'S NAME (Type) Ching-Hui Tsai, M.D.	
23D. ADDRESS Maryland General Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 5-31-69		24C. NAME OF CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Windsor Mill Rd Bz 16 Co Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Galt, M.D.		25C. FUNERAL DIRECTOR Burke Funeral Home Bz 16 Md	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

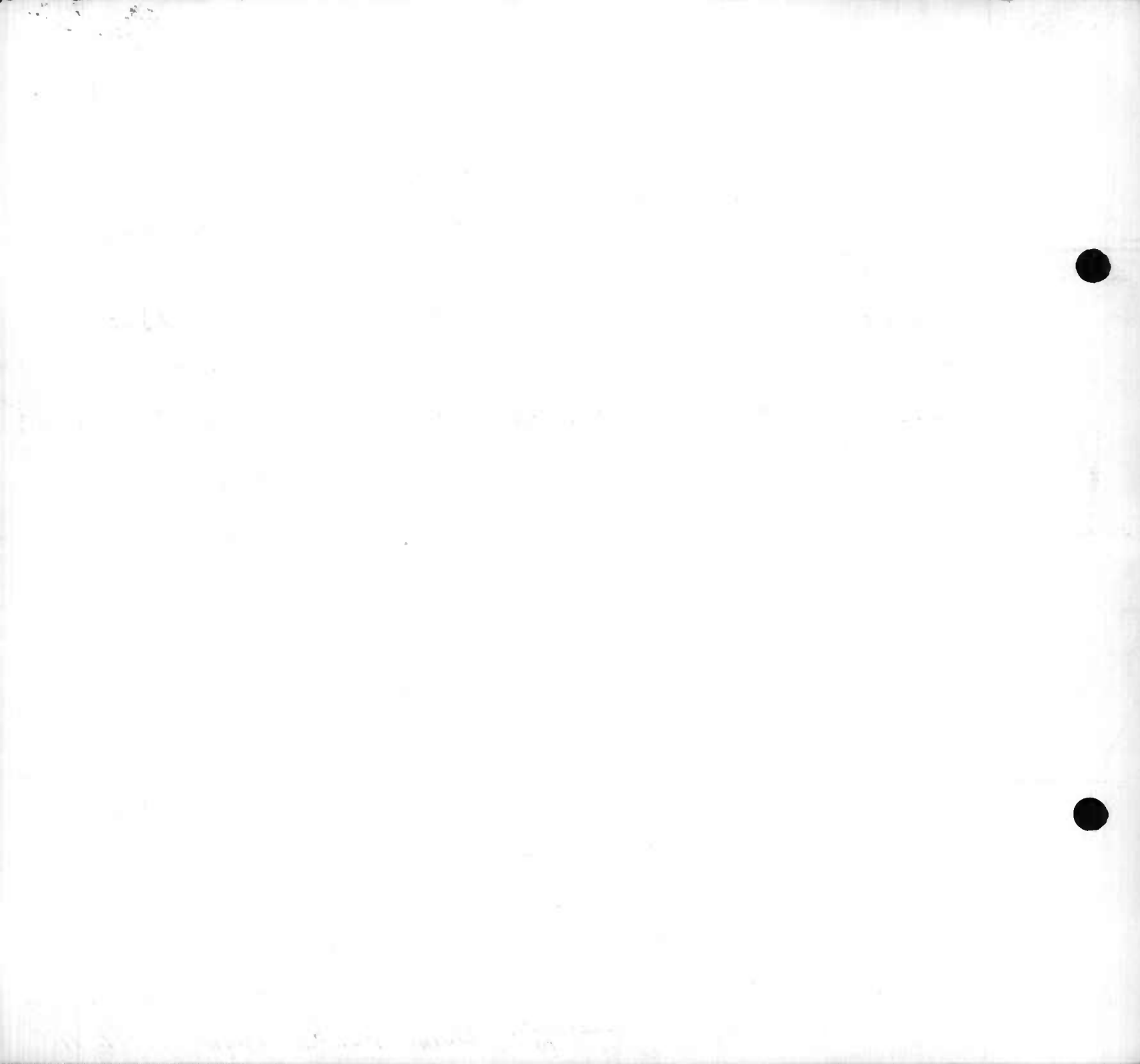
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 5513</u>
BIRTH NO. <u>69 5513</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Wood, George Gaither</u>		2. DATE AND HOUR OF DEATH <u>5/26/69</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Balt., Maryland.</u> B. COUNTY <u>13-06</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hosp of Balt</u>		C. CITY OR TOWN <u>Balt.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u>		6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/30/02</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Upholsterer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Transit Co</u>		9. AGE (In years last birthday) <u>66</u>
13. FATHER'S NAME <u>William Samuel Wood</u>		14. MOTHER'S MAIDEN NAME <u>Marg Ellen Eyles</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>13-10-0423</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
17. INFORMANT <u>Catherine M Vitilio</u>		ADDRESS <u>3507 Keswick Rd</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarct</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Extension of M.I.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>5/19/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>myocardial infarct</u>
22. I certify that (I) (this hospital) attended the deceased from <u>5/26/69</u> 19 to <u>1:50</u> <u>5/26/69</u> that (I) (we) last saw the deceased alive on <u>1:50 PM 5/26/69</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>L. Goodman M.D.</u>				23B. DATE SIGNED <u>5/26/69</u>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>Sinai Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-29-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cem</u>
24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Balt Co Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1969</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Butterfield Funeral Home</u>		
25D. ADDRESS <u>Baltimore Md</u>				



FUNERAL DIRECTOR: IMPORTANT

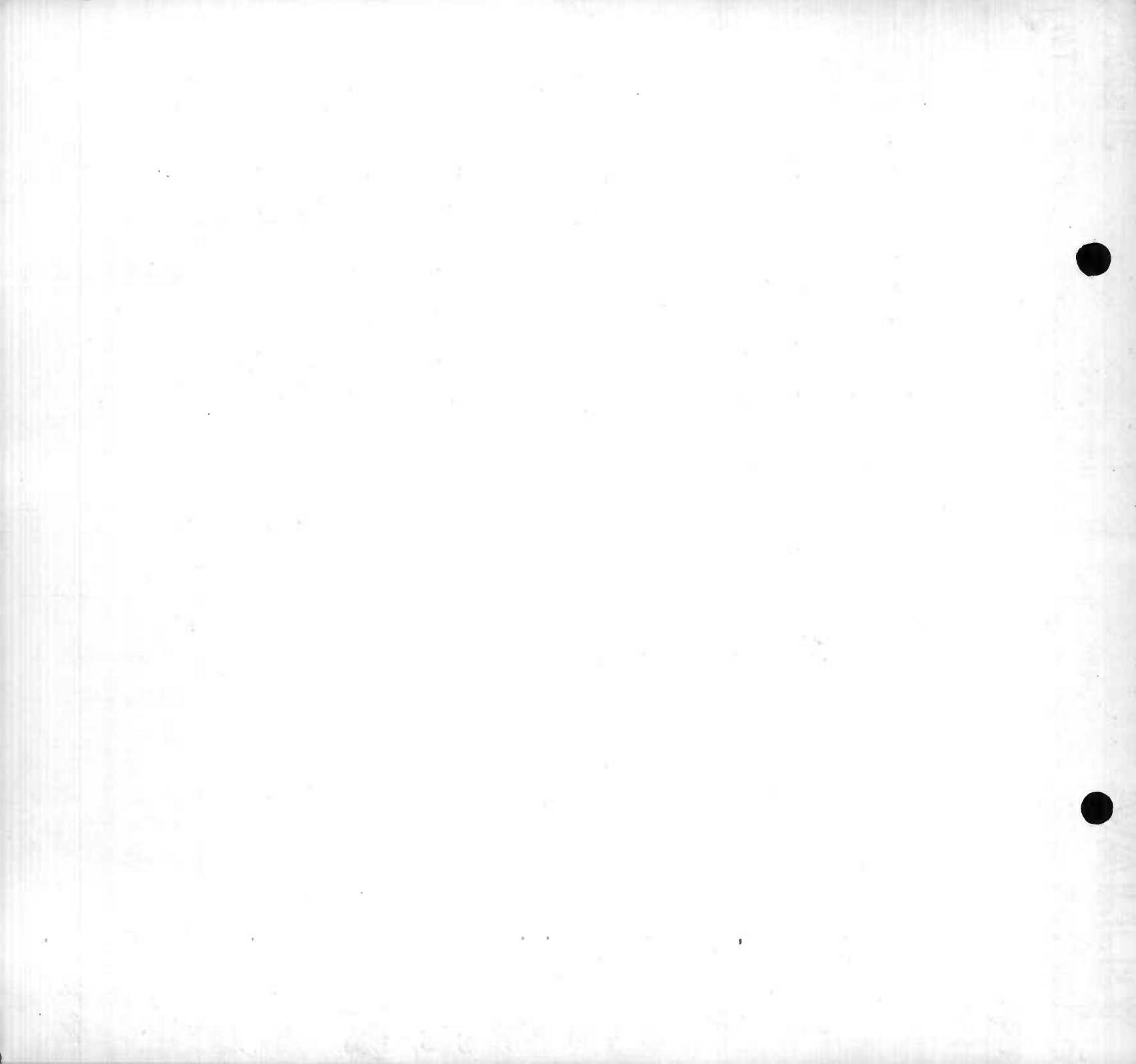
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5514	
BIRTH NO. 69 5514				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CHARLES W. WHITE			2. DATE AND HOUR OF DEATH 5/27/69 8:35 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 27-65		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4432 Clydesdale Ave		
5. SEX M	6. RACE Can	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/08	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10B. KIND OF BUSINESS OR INDUSTRY Industrial		11. BIRTHPLACE (State or foreign country) PENNA.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Joseph Edmund White		
14. MOTHER'S MAIDEN NAME Susie E. Jones			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no (unknown)) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 187163723			17. INFORMANT Joan J. Vodusek		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GI bleeding ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cirrhosis of liver			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 1 year		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 5/21/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 5/21/69 to 5/27/69 and that (I) (we) lost saw the deceased alive on 5/27/69 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eric Juditz				23B. DATE SIGNED 5/27/69	
23C. PHYSICIAN'S NAME (Type) ERIC JUDITZ				23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-31-69		24C. NAME OF CEMETERY OR CREMATORY Calvary EUB. Cem	
24D. LOCATION (City, town, or county) (State) Wiconisco, Dauphin Co, Pa		25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969			
25B. NAME OF REGISTRAR W. E. Gaber, M.D.		25C. FUNERAL DIRECTOR BURGER PONSER Home, Balto Md			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MAY W Lowe		May 28 1969 8:20 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		27-55	
90 The Wesley Home 2211 W Rogers Ave		Md Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX 6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9. AGE (In years last birthday)	
Female White				June 21 1872 96	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		-		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Elijah Ward		Carrie Adams		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No -		218 52 2418		Wesley Home Records Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Acute Cardiac Decompensation 12 hr	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Arteriosclerotic Cardiovascular Disease 1 yr	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 19 to MAY 28 1969, that (1) (we) last saw the deceased alive on MAY 28 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Clarence W. LeDoux		5/28/69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Clarence W. LeDoux		M.D. 3023 Eastern Ave. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		29 May 69		Woodlawn Cem	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 2 1969		James E. Taylor, M.D.		Burger Funeral Home Balto Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5516	
BIRTH NO. 69 5516		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 5-27-69 8:40 P.M.	
1. NAME OF DECEASED (Type or Print) WILLIAM ROSS FARDWELL		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - Clerical Plumbing		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 5-29-84	
13. FATHER'S NAME WILLIAM ROSS FARDWELL		14. MOTHER'S MAIDEN NAME MINNIE MC GLAUGHLIN		9. AGE (In years last birthday) 84	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-54-2682-T		11. BIRTHPLACE (State or foreign country) MARYLAND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH SUPPURATIVE CHOLANGITIS		17. INFORMANT UTAI RUANGWIT, M.D. FRANKLIN SQ. HOSP.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
19A. DATE OF OPERATION 5-25-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-25-69 to 5-27-69 that (I) (we) last saw the deceased alive on 5-27-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Utai Ruangwit, M.D.		23B. DATE SIGNED 5-27-69		23C. PHYSICIAN'S NAME (Type) UTAI RUANGWIT, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-31-69		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR Borzyce Funeral Home	
24D. LOCATION (City, town, or county) Baltimore Md		24E. LOCATION (City, town, or county) Baltimore Md		24F. LOCATION (City, town, or county) Baltimore Md	

A-2001

69 5517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH69 5517
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ASH, ARTHUR F.		8:50 AM 5/30/1969 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital				A. STATE Md 501 W. 28th St. 13-07	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 501 W 28th St	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/22/92	9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofers		10B. KIND OF BUSINESS OR INDUSTRY Home Repairs		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Henry Ash				14. MOTHER'S MAIDEN NAME Mary	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217 010592		17. INFORMANT Florence R Ash above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 157.9 I Disease or condition directly leading to death Antecedent causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma pancreas metastasis to liver (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 5/22/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cataract		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/15/69 to 5/30/69 that (I) (we) last saw the deceased alive on 5/30/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Budwai				23B. DATE SIGNED 5/30/69	
23C. PHYSICIAN'S NAME (Type) A. Budwai				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-2-69		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park	
24D. LOCATION Baltimore, Md.		24E. NAME OF REGISTRAR JUN 2 1969		24F. FUNERAL DIRECTOR Burgess Funeral Home Balto Md	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO.

69 5518

BIRTH NO. 68-2936

1. NAME OF DECEASED
(Type or Print)

Neary, Barbara A.

2. DATE AND HOUR OF DEATH

May 29th, 1969

11:08 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Saint Agnes Hospital
Caton & Wilkens Aves. 212294. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

616 Lucia Ave. 21229

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

2-13-1968

9. AGE (in years
last birthday)

15 Months

10. Under 1 Yr. 11. Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John C. Neary

14. MOTHER'S MAIDEN NAME

Dolores R. Williams

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. John C. Neary, 616 Lucia Ave. 21229

18. 036.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

8 hrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 29 May 19 69 to 29 May 19 69
that (I) (we) last saw the deceased alive on 29 May 19 69 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John K. Weagley M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

29 May 1969

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

John Weagley M.D.

St. Agnes Hospital, Wilkens & Caton Avenues

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

5-31-1969

24C. NAME OF CEMETERY or CREMATORY

Glen Haven Cemetery

24D. LOCATION

(City, town, or county)

(State)

Glen Burnie, Anne Arundel Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 2, 1969

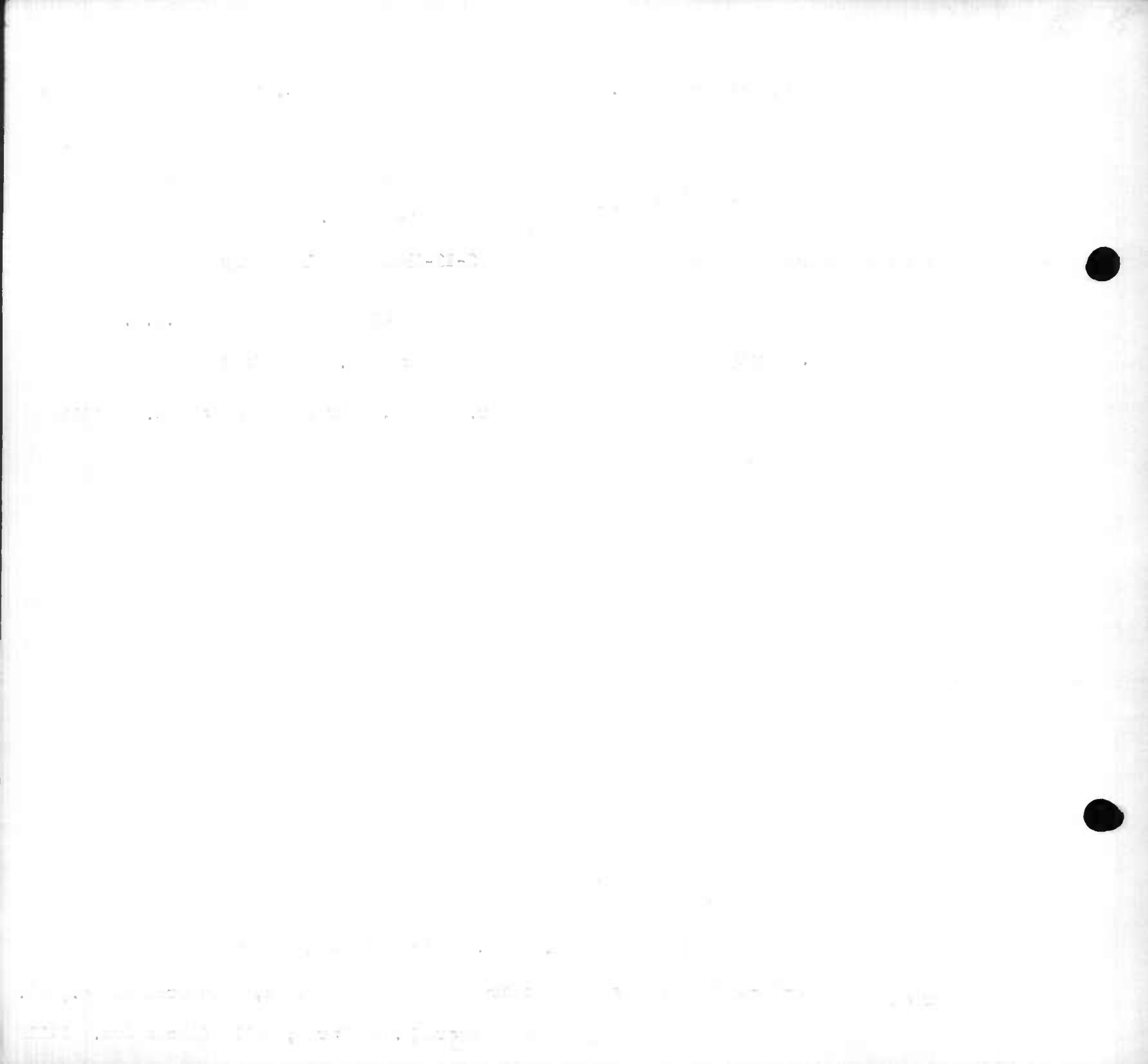
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

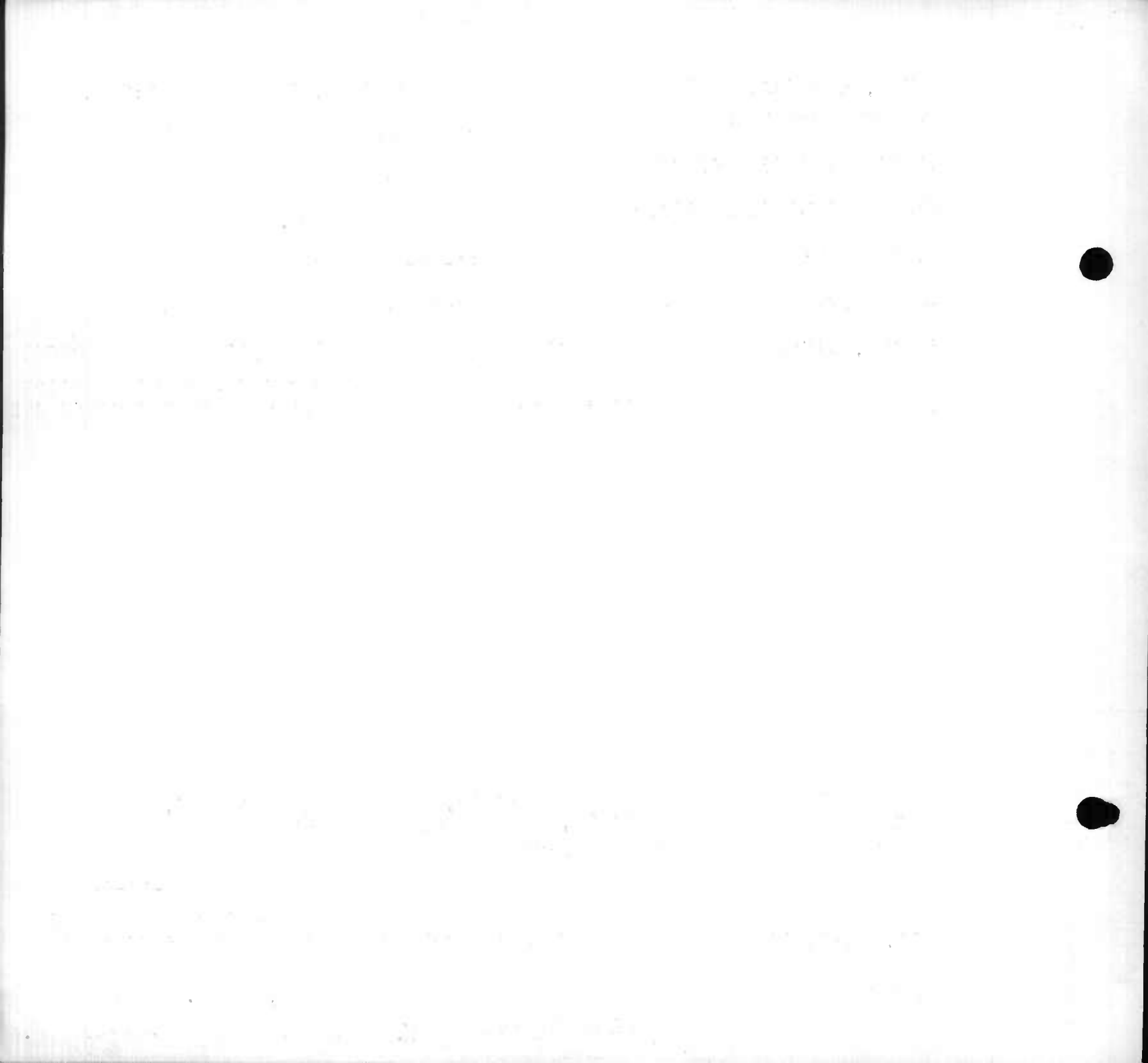
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5519	
BIRTH NO. 69 5519				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) DIXON, LAWRENCE ELMER			2. DATE AND HOUR OF DEATH MAY 30, 1969 13:50A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Balto. co. 53-80		
FULL NAME OF HOSPITAL OR INSTITUTION WILKENS & CATON AVENUES			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION BALTIMORE MARYLAND 21229			E. STREET AND NUMBER 1407 Lafayette Ave.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-97	9. AGE (in years last birthday) 71	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER		10B. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME EDWARD, DIXON DEC 'D			14. MOTHER'S MAIDEN NAME (Biggs) NELLIE DEC 'D		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 16 9205		17. INFORMANT RECORD'S BALTIMORE MD 21229	
			ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Peripheral vascular shock</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>electrolyte imbalance and loss of cardiac fluid</i>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>liver cancer</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 5-31-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from MAY 29, 1969 to MAY 30, 1969 that (X) (we) last saw the deceased alive on MAY 30, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE <i>Dr. Revillia</i>				23B. DATE SIGNED 5-30-69	
23C. PHYSICIAN'S NAME (Type) DR. REVILLIA				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE June 2 69		24C. NAME of CEMETERY or CREMATORY Woodlawn	
24D. LOCATION Woodlawn, Balto. co Md		24E. CITY, town, or county BALTIMORE		24F. STATE MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR John E. Starobury	
				ADDRESS 6411 Windsor Mill Rd.	

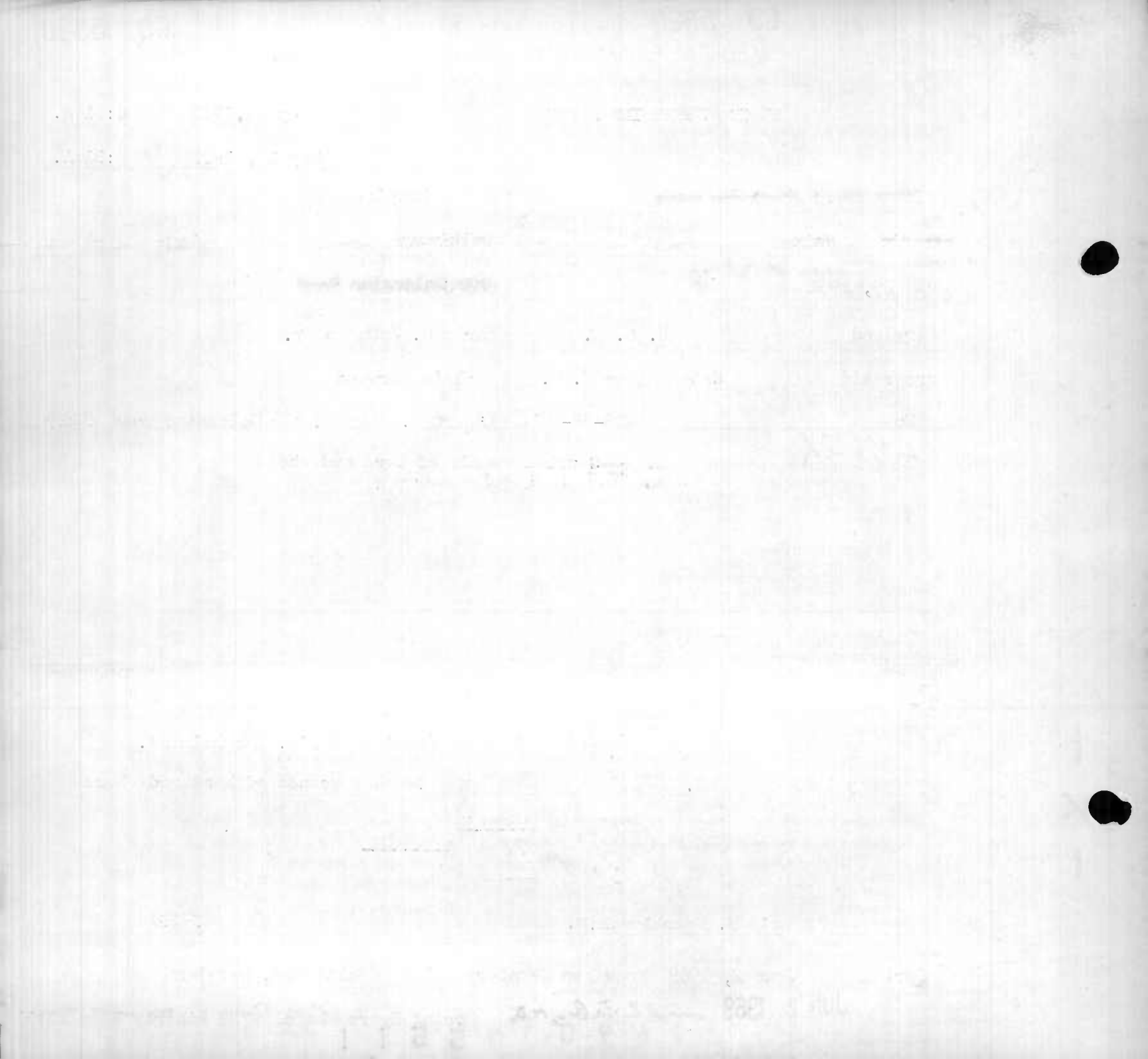


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

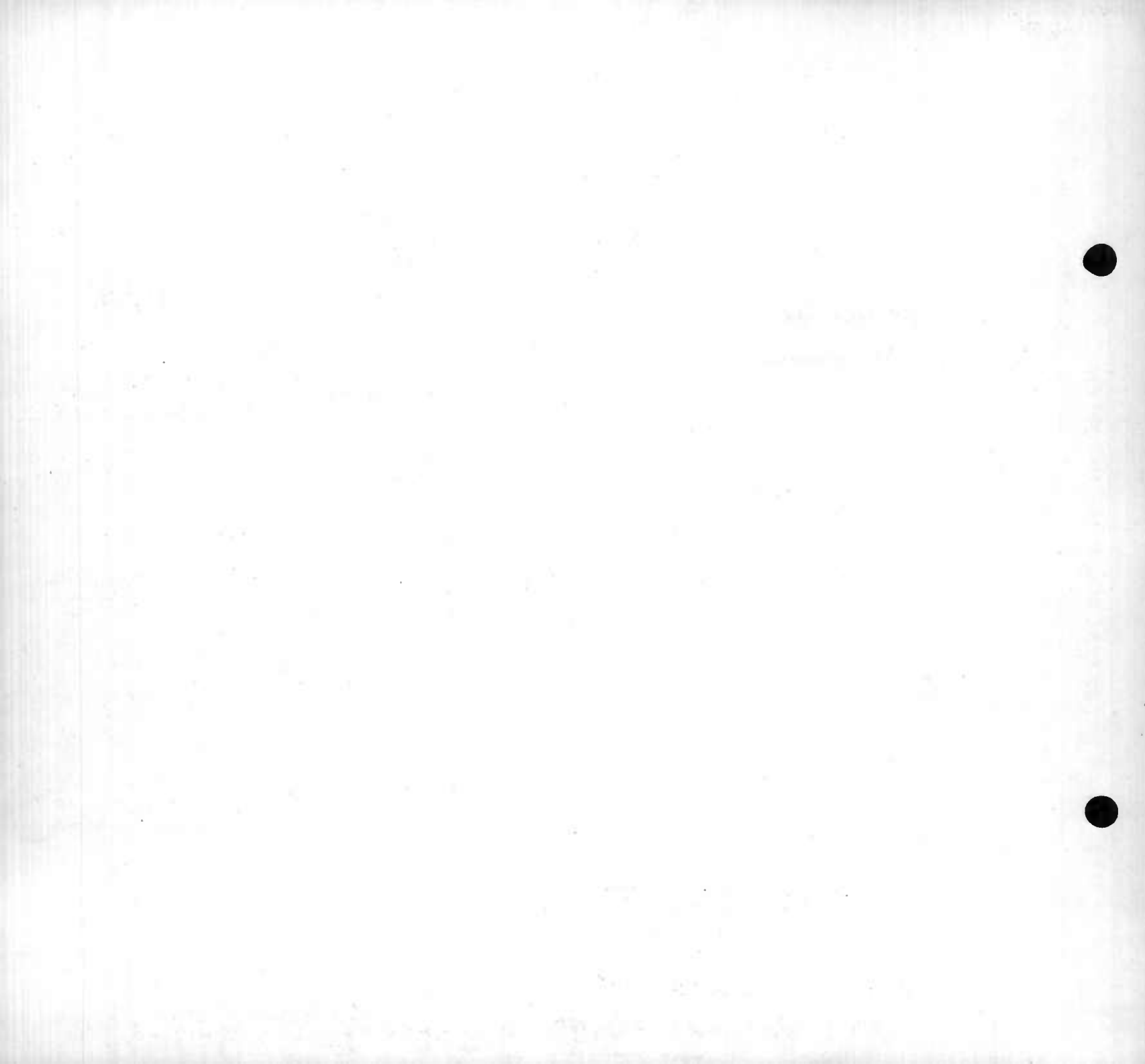
BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) ELSTIE JOSEPHINE JOHNSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 28, 1969 Hour 6:31 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3900 Block Chesholm Road		3. DATE PRONOUNCED DEAD Month Day Year May 28, 1969 Hour 6:31 A. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH June 29, 1952		10. AGE (In years lost birthday) 16 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aid		14B. KIND OF BUSINESS OR INDUSTRY Caton Ridge N. H.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-58-3732	
15. MOTHER'S MAIDEN NAME Elsie Norwood		18. INFORMANT Edward E. Johnson	
19. E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Gunshot wounds of head and chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Wooded area	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Found 3900 Blk. Chesholm Rd.		22F. HOW DID INJURY OCCUR? Gunshot wounds of head and chest	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) May 1969 UNK.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 2, 1969	
24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Walter E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Loring Byers Chapel		ADDRESS 8728 Liberty Road 21133	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

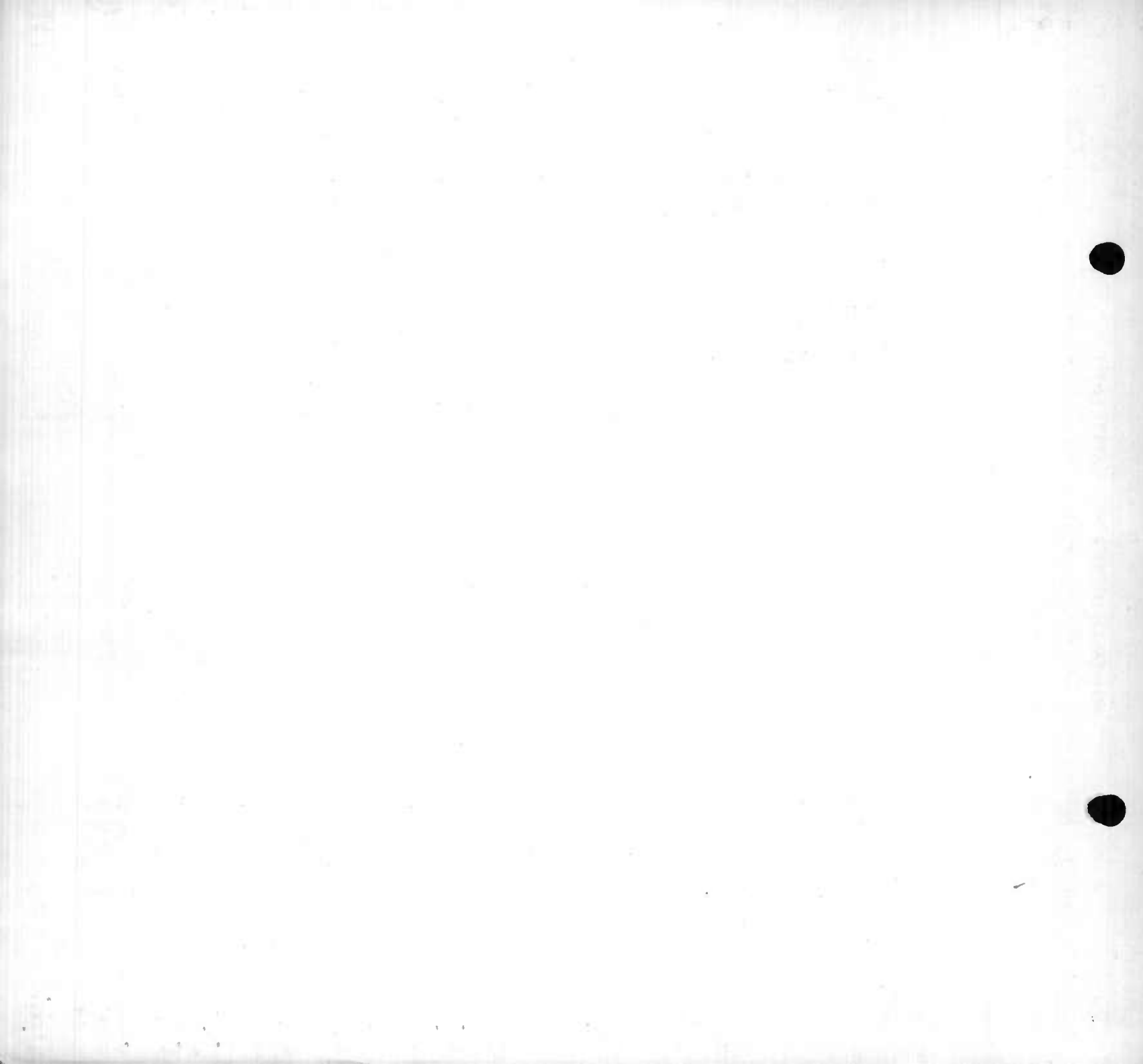
BIRTH NO.				BALTIMORE CITY HEALTH DEPT.		REG. NO. 209 5521	
1. NAME OF DECEASED (Type or Print) <i>Hartman E. Elizabeth</i>				2. DATE AND HOUR OF DEATH <i>6:45 am 6/1/69</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>901213 L. St. - Balto. Md. - Harbor View Nursing Center</i>				A. STATE <i>MD</i>		B. COUNTY <i>27-33</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Balto Md</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER							
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/12/1878</i>		9. AGE (In years last birthday) <i>91</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>?</i>		11. BIRTHPLACE (State or foreign country) <i>York, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Rebecca German</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary S. Kern</i>		
					ADDRESS <i>26 Buckeye Rd. - Emmons Pa 15049</i>		
18. <i>412.31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>48 Hours</i>	
				(B) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>years</i>	
				(C) <i>debility & renal pathology</i> <i>Parkinson's Disease</i>		<i>months</i> <i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5/23 1969</i> to <i>6/1 1969</i> , that (I) (we) lost saw the deceased alive on <i>6/1 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Al Macht</i>				23B. DATE SIGNED <i>6/1/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT MD</i>				23D. ADDRESS <i>2 E Real St Balto MD 21202</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 5, 1969</i>		24C. NAME OF CEMETERY or CREMATORY <i>Union Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Islen Rock York Co. Pa.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 2 1969</i>		25B. NAME OF REGISTRAR <i>John E. Talbot, Jr.</i>		25C. FUNERAL DIRECTOR <i>John E. Talbot, Jr.</i> ADDRESS <i>Islen Rock, Pa.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

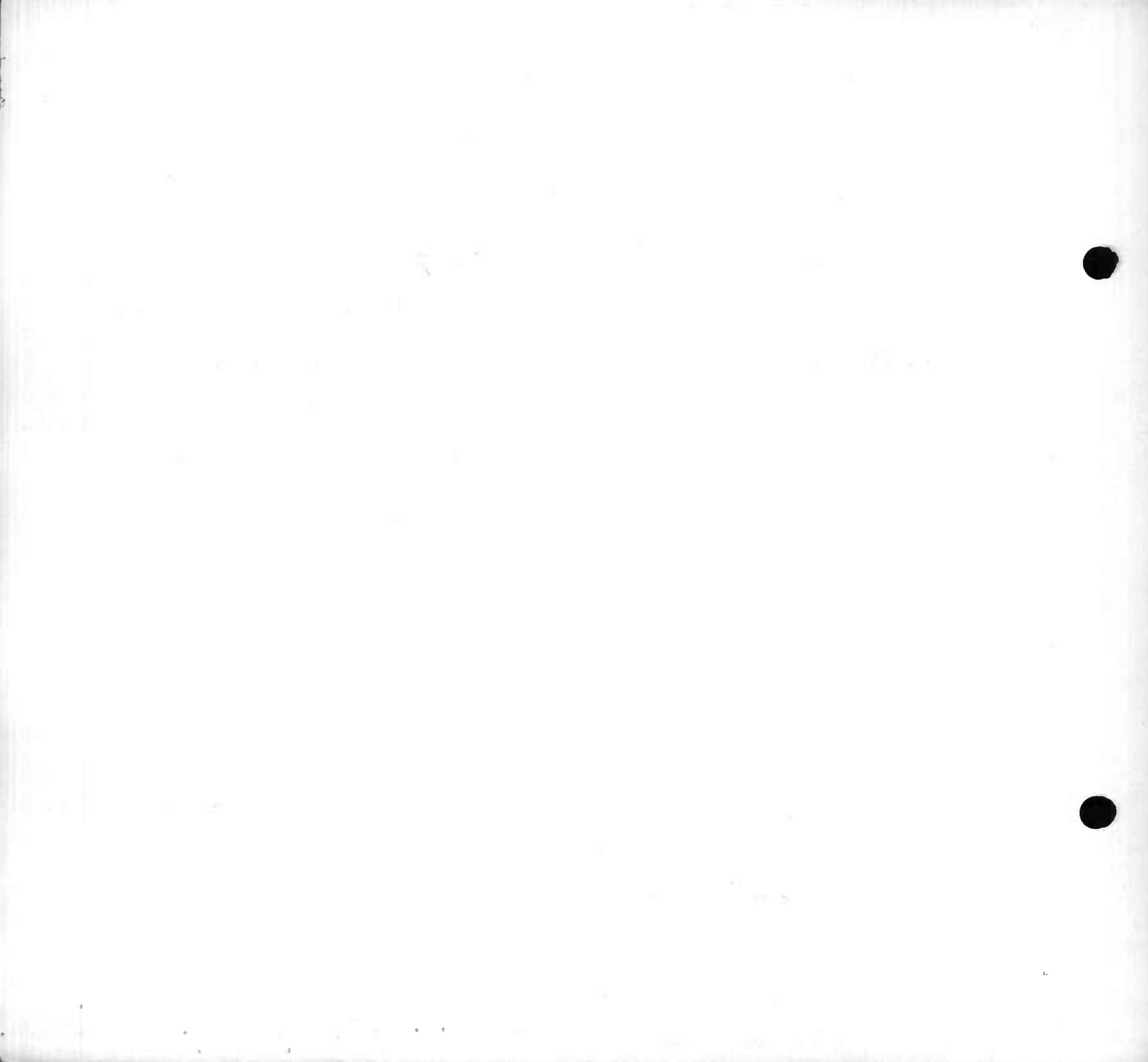
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5522
BIRTH NO. 69 5522		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) CLEMENTS, KATHERINE I.		2. DATE AND HOUR OF DEATH 5-29-69 9 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION HILLREST N. H.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ADDRESS OR LOCATION 212 Stoney River La. Baltimore		E. STREET AND NUMBER 1130 Webb Ct.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1885	9. AGE (In years lost birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Higgins		
14. MOTHER'S MAIDEN NAME Mary D. ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 062-523-6272		17. INFORMANT Rev G. S. Schwind, Balto, Md		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11-27-1968 to 5-29-1969 , that (I) (we) last saw the deceased alive on 5-27-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Vicente M. Ruano MD		23B. DATE SIGNED 5-29-69		23C. PHYSICIAN'S NAME (Type) VICENTE M. RUANO MD
23D. ADDRESS 1632 Reisterstown Rd. Pk. Peter Md		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 6/2/69	24C. NAME OF CEMETERY or CREMATORY Loudon Park	24D. LOCATION Baltimore Md.	25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969	
25B. NAME OF REGISTRAR Robt E. Taylor, Md.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

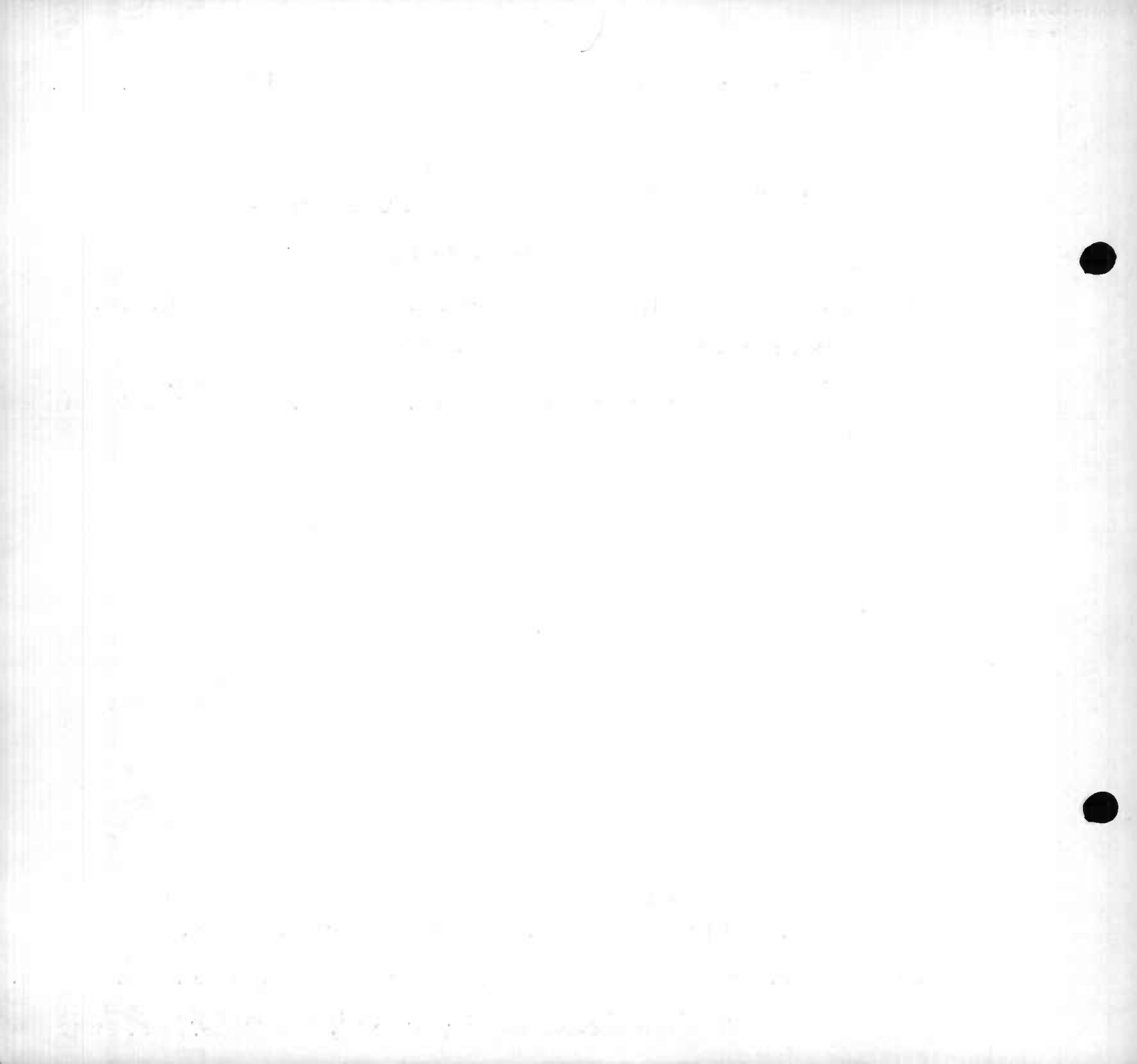
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 5523</u>
BIRTH NO. <u>69 5523</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>John Clendenin Corckran</u>		2. DATE AND HOUR OF DEATH <u>5-31-69</u> <u>8:30A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital - Maryland</u>		A. STATE <u>Maryland</u> B. COUNTY <u>27-12</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>5300 Purlington Way</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-10</u>	9. AGE (In years last birthday) <u>58</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRES. CLENDENIN BROS. INC.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BRASS & COPPER</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>James G. Corckran</u>		14. MOTHER'S MAIDEN NAME <u>Marian Mister</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-4934</u>		17. INFORMANT <u>MRS. LUCILLE B. CORCKRAN</u> (<u>HO-PITAL</u> <u>CHART</u>)
18. <u>441101</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 HOURS</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Dissecting Aortic Aneurysm</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>4 DAYS</u> (C) _____		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>YES</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>5-26</u> 19 <u>69</u> to <u>5-31</u> 19 <u>69</u> that (I) (<u>we</u>) last saw the deceased alive on <u>5-31</u> 19 <u>69</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.				
23A. SIGNATURE <u>Jerry Salan, M.D.</u>		23B. DATE SIGNED <u>5/31/69</u>		
23C. PHYSICIAN'S NAME (Type) <u>JERRY SALAN, M.D.</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL, BALTO., MD.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/3/1969</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1969</u>	25B. NAME OF REGISTRAR <u>Robert E. Fabel, M.D.</u>	25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

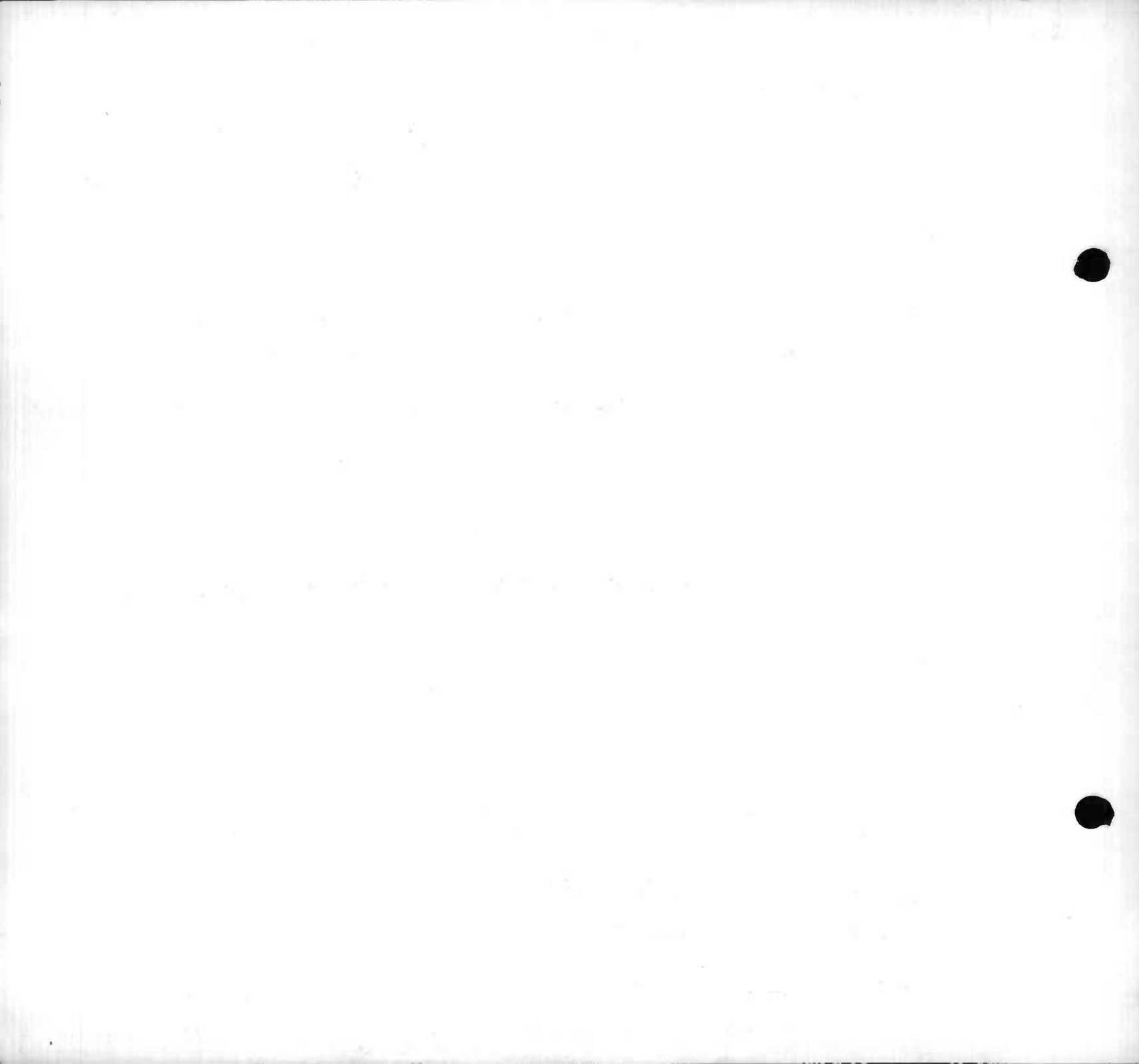
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5524	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 69 5524 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Ellen F. Coston			2. DATE AND HOUR OF DEATH May 28, 1969 11:30 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 922 W. University Parkway			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 27-14		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 922 W. University Parkway		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-15-1875	9. AGE (In years lost birthday) 93	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Americus James Souder			14. MOTHER'S MAIDEN NAME Jane Frazier		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-18-6108 A		17. INFORMANT Apt. 27A Mrs. Robert B. Rector 922 University Pw	
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia	
				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). art. scl cv disease					
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 2/6 1965 to 5/28 1969 that (1) (we) lost saw the deceased alive on 5/28 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Maurice Feldman				23B. DATE SIGNED 5/29/69	
23C. PHYSICIAN'S NAME (Type) Dr. Maurice Feldman, Jr.		23D. ADDRESS 6610 Cross Country Blvd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5-31-1969	24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Balto., Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Farber, R.D.		25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4505 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 69 5525	
BIRTH NO. 69 5525		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) ERICH C. WEDEMAN				2. DATE AND HOUR OF DEATH 5-29-69 12 55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Mc. General		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Pa. B. COUNTY Baltimore		C. CITY OR TOWN Philadelphia	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 8328 Old Philadelphia Rd.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-99	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician			10B. KIND OF BUSINESS OR INDUSTRY Allied Chem.		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ferdinand			14. MOTHER'S MAIDEN NAME Wilhelmina Ashbach				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-05-1207		17. INFORMANT Hospital		ADDRESS 1 D. General
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Small bowel Intestine			CAUSE OF DEATH Small bowel Intestine				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of lung, metastasis				
			(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Tuberculosis				
			(C) Chronic Tuberculosis				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/29 19 69 to 5/29 19 69 that (I) (we) last saw the deceased alive on 5/29 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Marvin Sachs MD						23B. DATE SIGNED 5-29-69	
23C. PHYSICIAN'S NAME (Type) MARVIN C. SACHS, MD		23D. ADDRESS Mc. Gen. Hs.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-2-69		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Philip E. Cook		ADDRESS 1211 Chesaco Ave.	



S-530

69

5526

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69

5526

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MILDRED C. SCHMIDT

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

5

27

69

1:25 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

May

27,

1969

1:25 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

13-07

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Apr. 12, 1898

10. AGE (in years
last birthday)

71

If Under 1 Yr. If

Months Days Hours Min.

E. STREET AND NUMBER

3939 Roland Ave. Apt. 318

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

Archibald Marshall

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

Muth Bros. Drug Co.

15. MOTHER'S MAIDEN NAME

Elsie Schuster

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

211-30-2788

18. INFORMANT

Mr. Jno. L. Marshall Jr.

ADDRESS

Tenally, N.J.

49 Walnut Ave

19.

412.4

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 28, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5/29/69

24C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 2 1969

25B. NAME OF REGISTRAR

Robert E. Fahey, M.D.

25C. FUNERAL DIRECTOR

Ann Donovan - 3818 Roland Ave.



WALL BUILDING

DISCONTINUED

2000 2000 2000 2000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 69 5527
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mrs. Pauline E. Spann</i>		2. DATE AND HOUR OF DEATH <i>May 28/1969 4:15 P. M.</i>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED <i>North Charles General Hosp.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>26-09</i>		
5. SEX <i>F</i>		6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 29/1892</i>
9. AGE (in years, last birthday) <i>76</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Louis Kapple</i>		14. MOTHER'S MAIDEN NAME <i>Hape</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs. Marie Machniak</i>
18. <i>4-10-91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerotic Cardiovas. Disease</i>		(B) <i>Anemia, Etiology Unknown</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Manuel A. Gonzon M.D.</i>		23B. DATE SIGNED <i>May 28, 1969</i>		23C. PHYSICIAN'S NAME (Type) <i>MANUEL A. GONZON</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-31-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 2 1969</i>		
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Helma R. Hoffmann</i>		
25D. ADDRESS <i>3218 Hudson St.</i>				

VS 153 6-10-69 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 5528</u>
69 5528				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>John T Rider</u>		
2. DATE AND HOUR OF DEATH <u>5/29/69</u>		9A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>18 Maryland General Hospital</u>		A. STATE <u>MD</u> B. COUNTY <u>Balt.</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>8/29/11</u>		9. AGE (In years last birthday) <u>57</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter Home Improvement Bus</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Benjamin Rider</u>		
14. MOTHER'S MAIDEN NAME <u>Armenta De Haver</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sarah Veriter</u> ADDRESS <u>4634 Reisterstown Road</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>PULMONARY EMBOLIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>CARDIAC FAILURE</u>		
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA of RECTUM</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>GI Bleeding</u>				
19A. DATE OF OPERATION <u>4/17 ; 4/22</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cg Rectum, Intest. Obs.</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>
22. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> 19 <u>69</u> to <u>5/29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>5/28</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>B. Ann Wood</u>		23B. DATE SIGNED <u>5/29/69</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>B. Ann Wood</u>		23D. ADDRESS <u>—</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-2-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Lakeview Cemetery</u>
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1969</u>		
25B. NAME OF REGISTRAR <u>John E. Talbot, M.D.</u>		25C. FUNERAL DIRECTOR <u>Armacost Funeral Chapel</u>		
25D. ADDRESS <u>4600 Liberty Ht.</u>				

Sarah V. Rider - 4634 Reisterstown Road

NO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500		BALTIMORE CITY HEALTH DEPARTMENT		69 5529	X	REG. NO. 69 5529
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SAMUEL P. COHEN		2. DATE AND HOUR OF DEATH 5/28/69 16:25 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1308 Saddleback Rd		
5. SEX MALE	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/96	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WHOLESALE		10B. KIND OF BUSINESS OR INDUSTRY MERCHANT		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME PHILIP COHEN		14. MOTHER'S MAIDEN NAME BRAUNA ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. ANNE COHEN, 1308 SADDLEBACK ROAD #21208				
18. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			(C) 2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Gastrointestinal Hemorrhage			1 week	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?				
22. I certify that (X) (this hospital) attended the deceased from 5/21/69 19 to 5/28/69 19 that (X) (we) last saw the deceased alive on 5/28/69 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Eric J. Juretz		23B. DATE SIGNED			23C. PHYSICIAN'S NAME (Type) ERIC JURETZ	
23D. ADDRESS SINAI HOSPITAL		23E. DEGREE				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 5-29-69	24C. NAME of CEMETERY or CREMATORY SHAAREI ZION		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		

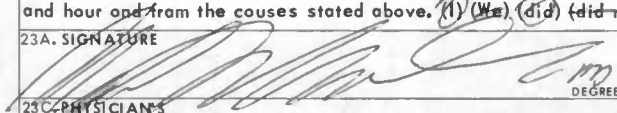
FUNERAL DIRECTOR: IMPORTANT

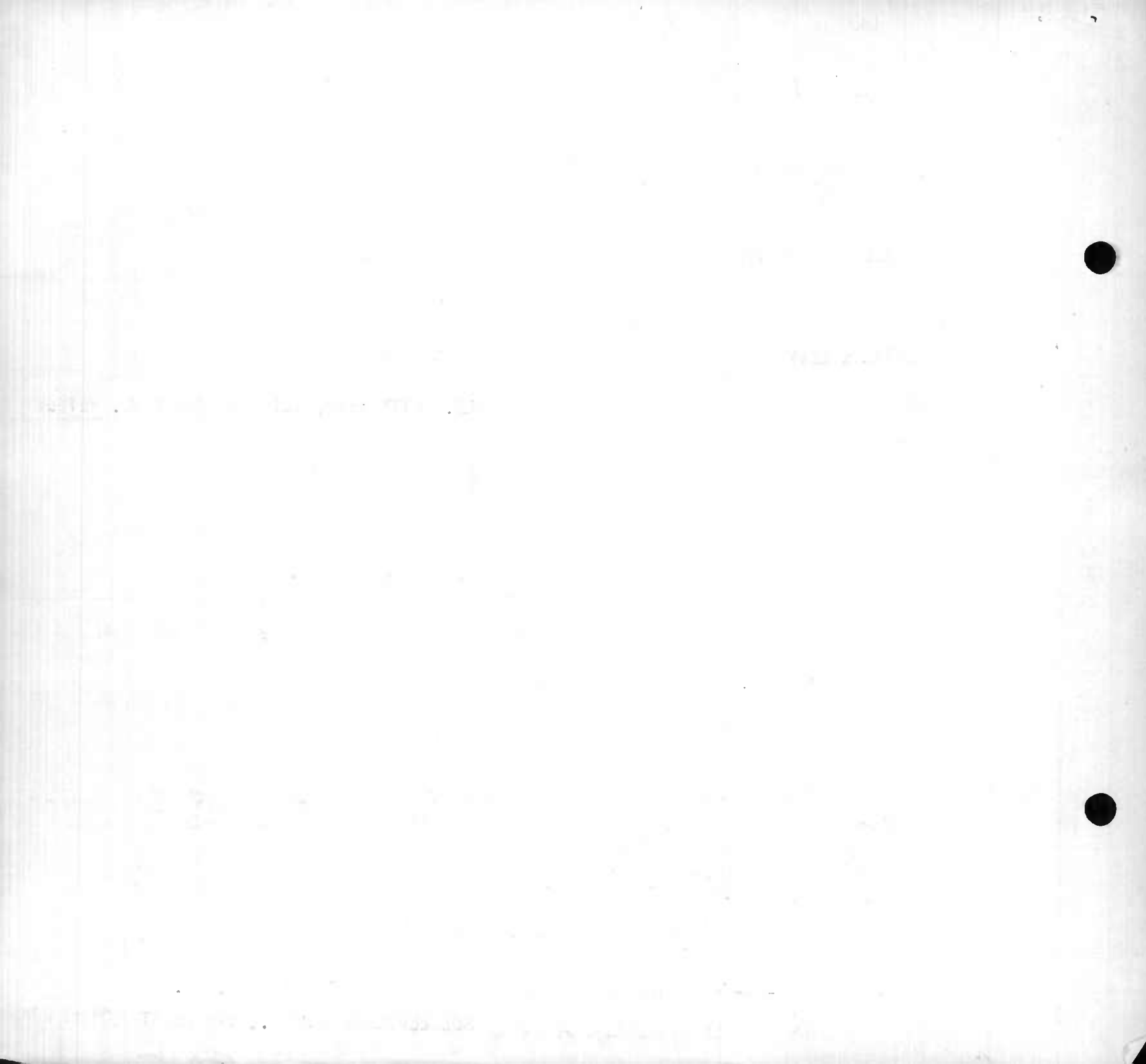
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5530
E-123 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Epstein, FANNIE		69 5530 CERTIFICATE OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOUSE IN THE PINES, BELVEDERE 90		2. DATE AND HOUR OF DEATH MAY 27 1969 11 30/8 M. 27-17 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3317 W. ROGERS AVENUE		
5. SEX FEMALE 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	6. RACE WHITE 10B. KIND OF BUSINESS OR INDUSTRY AT HOME	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH APRIL 12, 1885 9. AGE (In years lost birthday) 84 11. BIRTHPLACE (State or foreign country) POLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME SAMUEL SADOVE		14. MOTHER'S MAIDEN NAME GAIL LIBBY ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 17. INFORMANT DR. CHARLES EPSTEIN, GREENLEA DRIVE #21208 ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 17481 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Carcinoma breast DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 1961		
22. I certify that (I) (this hospital) attended the deceased from 1961 19 to 5/27/69 19 that (I) (we) last saw the deceased alive on 5/27/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Joseph Shear MD		23B. DATE SIGNED 5/27/69		
23C. PHYSICIAN'S NAME (Type) Joseph Shear MD		23D. ADDRESS 6705 Park Heights Ave		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-29-69 24C. NAME of CEMETERY or CREMATORY HAR ZION TIFERETH ISRAEL 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD ADDRESS		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-100		69 5531		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 5531	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) CHARLES OSCAR A LEVY					2. DATE AND HOUR OF DEATH 5-27-69 1035 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE BELVEDERE + GREENSPRING AVES					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN Pikesville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3210 Old Court Rd.				
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-11-03	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) president				10B. KIND OF BUSINESS OR INDUSTRY Amer. Totalisator Co.		11. BIRTHPLACE (State or foreign country) Illinois CHICAGO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN LEVY					14. MOTHER'S MAIDEN NAME UNKNOWN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. BETTY LEVY, 3210 OLD COURT RD. #21208			
18. 157.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE PULMONARY edema DUE TO, OR AS A CONSEQUENCE OF: (B) Acute CARDIAC Failure (C) post-exploratory laparotomy APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hours 7 hours									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CARCINOMATOSIS - 1/2 PANCREAS AS PRIMARY LESION									
19A. DATE OF OPERATION 5-27-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL MASS ASCITES		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 5-25 19 69 to 5-27 19 69 , that (1) (we) last saw the deceased alive on 5-27 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE 					23B. DATE SIGNED 5-27-69				
23C. PHYSICIAN'S NAME (Type) STEPHEN D. ROSENBAUM MD		23D. ADDRESS SINAI HOSPITAL OF BALTO.							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-29-69		24C. NAME OF CEMETERY or CREMATORY NEW HAR SINAI		24D. LOCATION (City, town, or county) (State) OWINGS MILLS, MD.			
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5532	
BIRTH NO. 69 5532					
1. NAME OF DECEASED (Type or Print)		CLARENCE VINSON		2. DATE AND HOUR OF DEATH 5/28/69 3:18 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 25-62		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE, MARYLAND			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX MALE 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 8-8-02 9. AGE (In years last birthday) 66		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HELPER ON TRUCK			11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		
13. FATHER'S NAME GIO VINSON			14. MOTHER'S MAIDEN NAME ARDELIA NUNA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217-05-7123		
17. INFORMANT BCH: RECORDS			ADDRESS 4940 EASTERN AVE. BALTIMORE, MD 21221		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RECURRENT SQUAMOUS CELL CARCINOMA OF MAXILLARY ANTRUM		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-12-69 to 5-28-69, that (I) (we) last saw the deceased alive on 5-28-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lee J. Cordova MD			23B. DATE SIGNED 5/28/69		
23C. PHYSICIAN'S NAME (Type) LEE J. CORDOVA MD.			23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE, MD. 21221		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31/69		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION Ann Arundel Co. Md.		24E. DATE REC'D BY HEALTH DEPT.			
25A. NAME OF REGISTRAR John E. Taylor MD.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Joseph H. Locks Jr.	
25D. ADDRESS 1304 N. Central Ave.					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5533	
BIRTH NO. 69 5533		CERTIFICATE OF DEATH		REG. NO. 69 5533	
1. NAME OF DECEASED (Type or Print) Amanda Parker		2. DATE AND HOUR OF DEATH 5/28/69		10:00 Am.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 9-08 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 729 E. 22nd Street			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/02	9. AGE (In years last birthday) 66	If Under 1 Tr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NOR FOLK VA.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME HARRY WILLIAMS		14. MOTHER'S MAIDEN NAME Amanda Williams			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Gladys McClurkin ADDRESS 1224 N. Potomac St.	
18. 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral vascular accident 36 hours		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive disease (B) DUE TO, OR AS A CONSEQUENCE OF: 4 years (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 5/28/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 5/26/69 5/28/69	
22. I certify that (I) (this hospital) attended the deceased from 5/28/69 19 to 5/28/69 19 that (I) (we) last saw the deceased alive on 5/28/69 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Kevin N. Hennessey, M.D.		23B. DATE SIGNED 5/28/69		23C. PHYSICIAN'S NAME (Type) Kevin N. Hennessey, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/2/69		24C. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEM.	
24D. LOCATION (City, town, or county) (State) BALTO. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Joseph J. Loggia Jr.		25D. ADDRESS 1304 N. Central Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

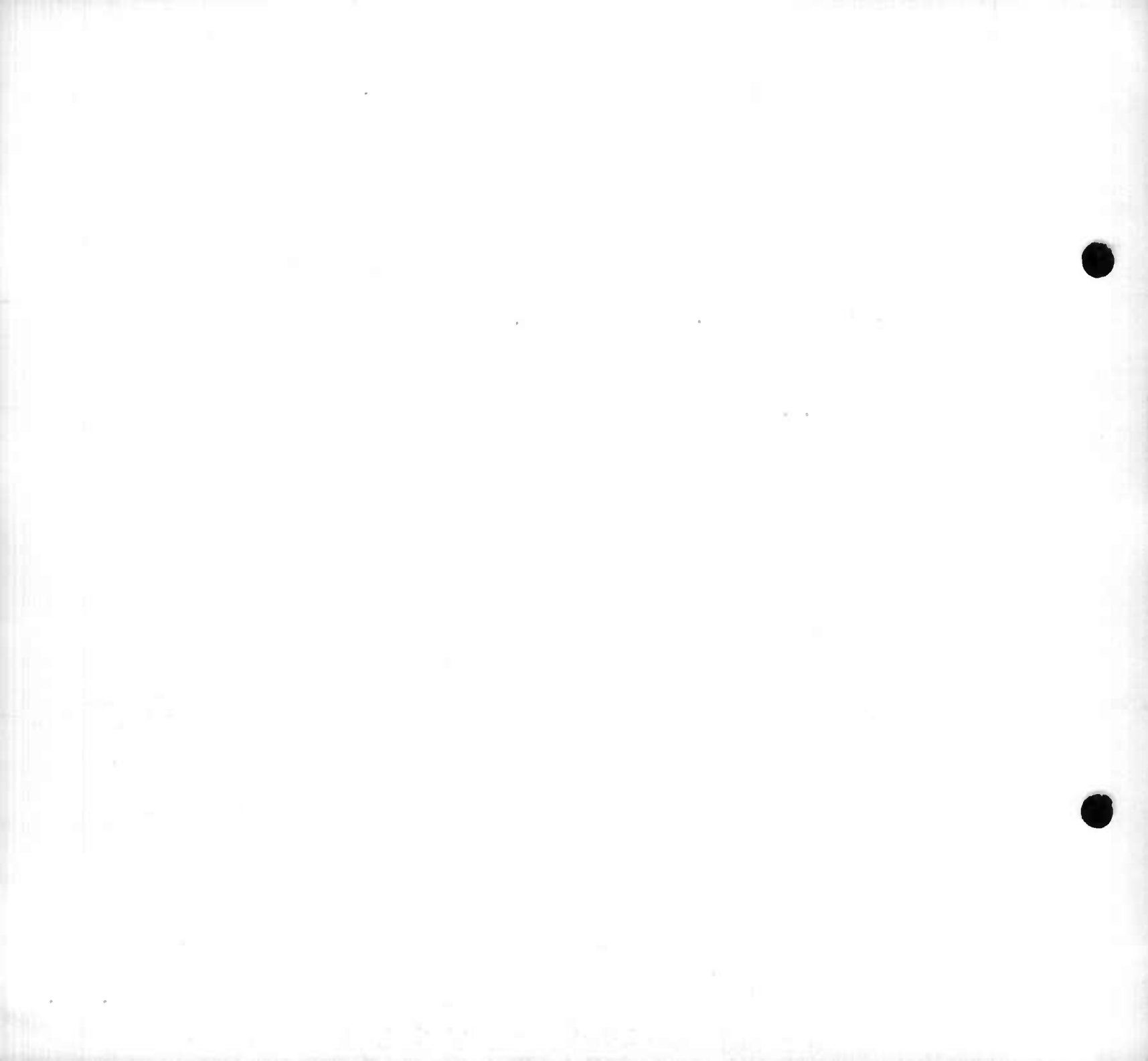
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5534	
CERTIFICATE OF DEATH					
BIRTH NO. 69 5534					
1. NAME OF DECEASED (Type or Print) <i>George Henry Mellema</i>			2. DATE AND HOUR OF DEATH <i>May 28 1969 9 20 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>			A. STATE <i>Maryland</i> B. COUNTY <i>Carroll Co.</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Westminster</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>38</i>			E. STREET AND NUMBER <i>Route 2</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/22/35</i>	9. AGE (in years last birthday) <i>34</i>	10. If Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>tree trimmer</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Asphmlth Inc Co</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			13. FATHER'S NAME <i>Clyde Mellema</i>		
14. MOTHER'S MAIDEN NAME <i>Anita Volk</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i>		
16. SOCIAL SECURITY NO. <i>215-32-5698</i>			17. INFORMANT <i>Mrs Evelyn L. Mellema</i>		
18. <i>450 X</i> CAUSE OF DEATH			ADDRESS <i>Westminster RT#2</i>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <i>Cardio-Respiratory Arrest</i> 4h.		
			(B) <i>Suspected Pulmonary Embolus</i>		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<i>Postop Dehiscence Closure</i> 6h.		
19A. DATE OF OPERATION <i>5/28/69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Dehiscence</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <i>5/17</i> 19 <i>69</i> to <i>5/28</i> 19 <i>69</i> that (H) (we) last saw the deceased alive on <i>5/28</i> 19 <i>69</i> and that (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John Jay Oldroyd M.D.</i>				23B. DATE SIGNED <i>5/28/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOHN JAY OLDROYD M.D.</i>				23D. ADDRESS <i>UNIVERSITY HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/1/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Bachman's Valley Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Westminster Rd Carroll Co Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 2 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, R.D.</i>	
25C. FUNERAL DIRECTOR <i>J. E. Meyer Jr</i>		ADDRESS <i>Westminster Md</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 69 5535	
BIRTH NO. 69 5535				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MR. Benjamin S. Wagner				2. DATE AND HOUR OF DEATH 5.29.69 1 9-15 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE & COUNTY Maryland Balto. Co. 53-00 C. CITY OR TOWN Baltimore 34 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3185 Hiss Ave			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.8.95		9. AGE (in years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY J. Norman Otto & Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME John Wagner				14. MOTHER'S MAIDEN NAME Lillian Yost			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 215-03-7333		17. INFORMANT wife		ADDRESS Same	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Post-cardiac Resuscitation? 3 day coma (B) Acute Myocardial Infarction 4 days DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5.25.1969 to 5.29.1969 that (I) (we) last saw the deceased alive on 5.29.1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Mohammed Sidig				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> Resident		23B. DATE SIGNED 5.29.69	
23C. PHYSICIAN'S NAME (Type) MOHAMMAD SIDIG M.B.B.S.				23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-31-1969		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Gardens		24D. LOCATION (City, town, or county) (State) Dulaney Valley Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 2 1969		J. E. F. B. M. D.		7401 Belair Rd.			



69 5536

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5536

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOSE

BASQUES

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
OR INSTITUTION ADDRESS OR LOCATION)

St. Agnes Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 27, 1969

8:30 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore (Easton)

YES ☐NO ☒

6. SEX

male

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)

39

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

32 Washington Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19. E815.01

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)II
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Craneo-Cerebral Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
street22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Beltway & 300 ft. N. of alternate US #1

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 4/27/69 4:40 A.M.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒22F. HOW DID INJURY OCCUR? Driver of car - went
out of control - struck a parked car

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/28/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

MAY 29 1969

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 2 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD

2

W. R. R. R.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5537

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 5537

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MICHAEL J. KAWECKI, SR.

2. DATE AND HOUR OF DEATH

May 26, 1969

9:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md. 21206

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4325 Brehms Lane

5. SEX

male

6. RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

June 10, 1891

9. AGE (In years last birthday)

77

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrician

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jacob Kaweck

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

219-30-3026

17. INFORMANT

ADDRESS

Minnie Zamponi Kaweck, wife, above

18.

412.41

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Cerebro-Vascular accident

A.S. C.V. D.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Sudden

5 yrs

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-9-68 19 to 5/25 1969, that (I) (we) last saw the deceased alive on 5/24 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. G. M. Baumgardner

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

5/28/69

23C. PHYSICIAN'S NAME (Type)

Dr. G. M. Baumgardner

23D. ADDRESS

8552 Philadelphia Road

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5/29/69

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 2 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane

Center-Independent
A.S.C.V.D.

2/22

2/24 1-11-08

2/21/09

1/11/09

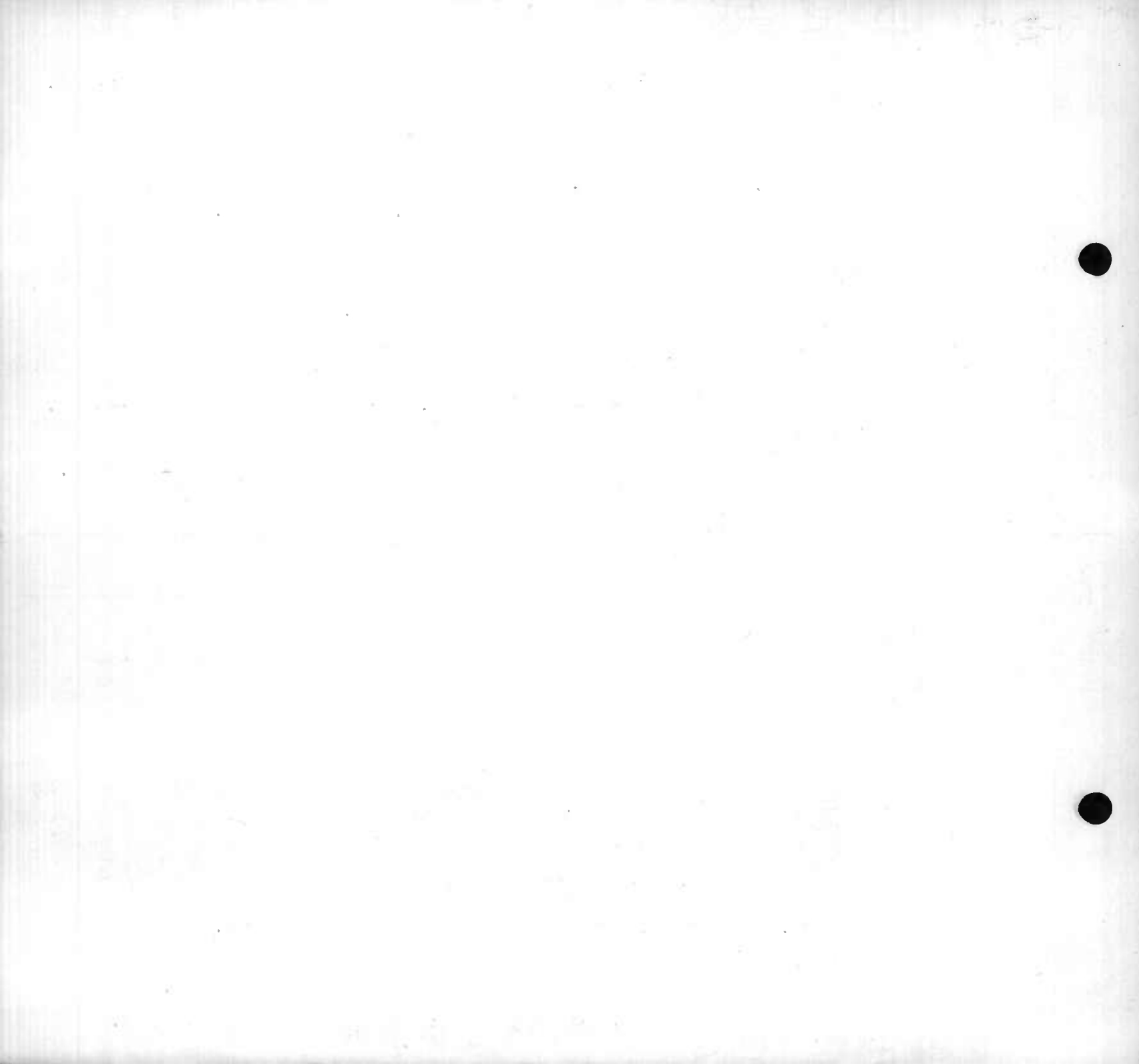
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5538

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY CATHERINE JACOBS		2. DATE AND HOUR OF DEATH May 25, 1969 7:15 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 14 XXX N. Highland Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md., 21224 B. COUNTY 26-10		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX female		6. RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/7/81		9. AGE (In years lost birthday) 87		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Plank		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-40-6301FZ		17. INFORMANT Mrs. Martin Huebschman, grand-dght. ADDRESS above	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic Cardio-vascular Disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 Yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 60 to May 25 19 69, that (I) (we) last saw the deceased alive on May 24 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Clarence W. DeDoux		23B. DATE SIGNED 5/28/69		23C. PHYSICIAN'S NAME (Type) Dr. Clarence W. DeDoux	
23D. ADDRESS 3023 Eastern Ave.		23E. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 53331 Grehms Lane			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/28/69		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. JUN 2 1969			
24F. NAME OF REGISTRAR Robert E. Taylor, M.D.		24G. ADDRESS 53331 Grehms Lane			



FUNERAL DIRECTOR: IMPORTANT

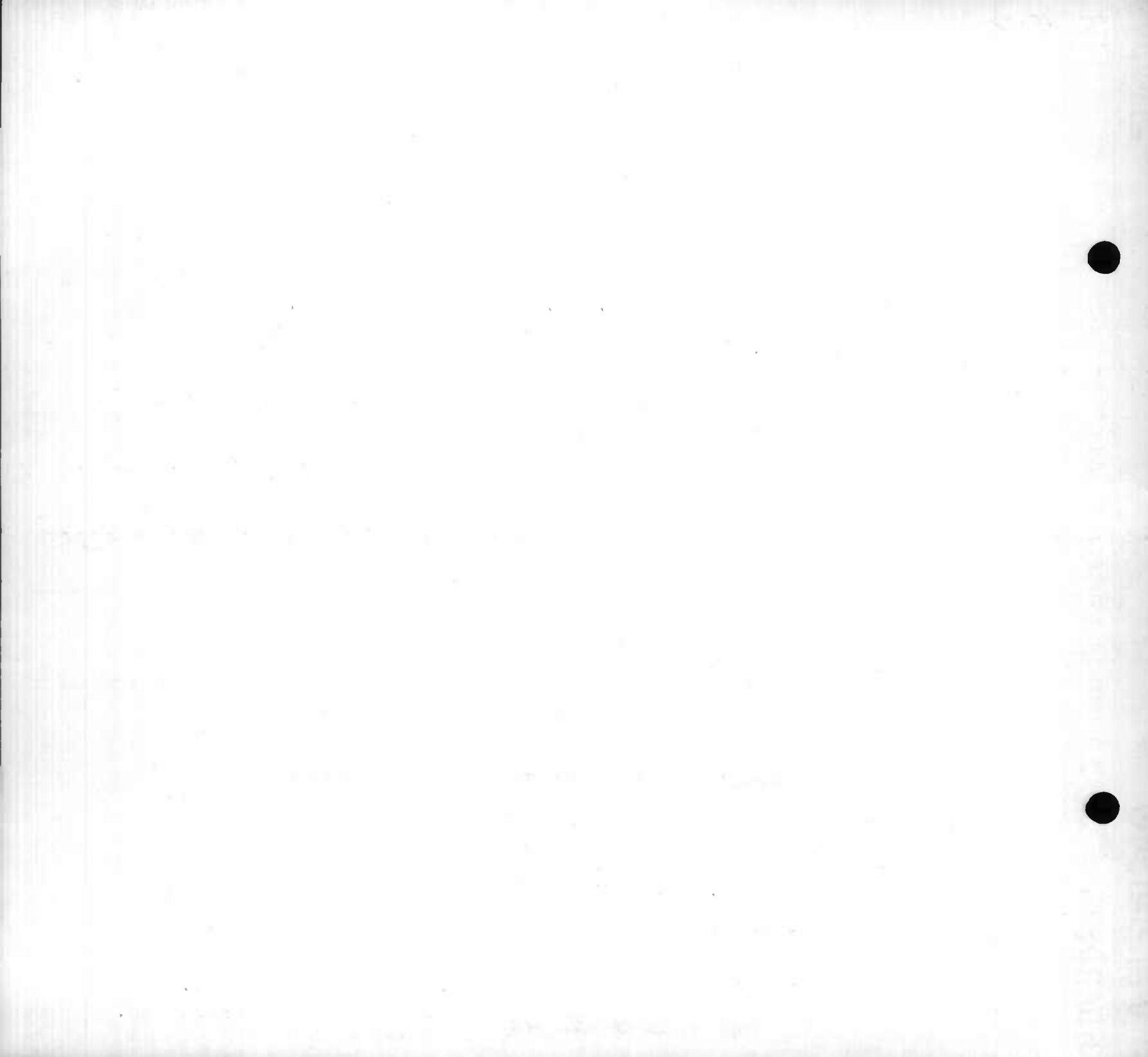
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 5539 CERTIFICATE OF DEATH

REG. NO. 69 5539

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARY KATHRYN LANAHAN		May 26, 1969 7 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
44 Union Memorial Hospital				Md. 21206	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				4702 Shamrock Avenue	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5/27/11	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Operator		C & P Tel. Co.		Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John G. Beil			Johanna Beckman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Lawrence Lanahan, husband, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410.01		Massive Myocardial Infarction		5-26-69	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) HYPERTENSIVE ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF:		9-18-66	
		(C) C.V. Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None		None		None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
None		None		None	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
None		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		None	
22. I certify that (I) (this hospital) attended the deceased from 9-18-66 19 to 5-26-69 19 that (I) (we) lost saw the deceased alive on 4-5-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. E. A. Schimunek				5-28-69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. E. A. Schimunek		842 S. East Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/29/69		Holy Redeemer Cem.	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 2 1969		James E. Talley, M.D.		Schimunek Funeral Home, Inc. 533310 Grehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5540	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MR. Addison B. Aul		2. DATE AND HOUR OF DEATH 5-29-69 12-10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland 21136 Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Reisterstown	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 124 Rockimmon Rd. 53-00	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-07-03	9. AGE (in years last birthday) 66	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY American Motors		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Edward G. Aul		14. MOTHER'S MAIDEN NAME Margaret Davidson			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 208-03-0506		17. INFORMANT James W. Keister 124 Rockimmon Rd. Reisterstown, Md. Son-in-law	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.91		CAUSE OF DEATH cardiogenic shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial infarction 21 day		(B) DUE TO, OR AS A CONSEQUENCE OF: pulmonary edema	
		(C) Diabetes mellitus with			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). arteriosclerotic cardiovascular disease				years.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-28-1969 to 5-29-1969 that (I) (we) last saw the deceased alive on 5-29-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mohammed Sidiq		DEGREE		23B. DATE SIGNED 5-29-69	
23C. PHYSICIAN'S NAME (Type) MOHAMMAD SIDIQ M.B.B.S.		DEGREE		23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 31, 1969		24C. NAME OF CEMETERY OR CREMATORY Homewood Cemetery	
				24D. LOCATION (City, town, or county) (State) Pittsburg, Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H. J. Schhardt	
				ADDRESS Owings Mills, Md.	



5-522

69 5541 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5541

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHN

~~SENTER~~ (Senkus)2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

May 29, 1969

4:25 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

34 BON SECOURS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

May 29, 1969

4:25 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

21-01

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12/22/1905

10. AGE (In years
lost birthday)

63

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

768 McHenry Street (21230)

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Senkus

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

14B. KIND OF BUSINESS OR INDUSTRY

Self employed

15. MOTHER'S MAIDEN NAME

Anna Bulotis

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

216-09-3698

18. INFORMANT

Mr. Home Robinson 1313 W. Lombard St.

ADDRESS

19.

412.2

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Hypertensive Arteriosclerotic Cardiovascular DISEASE

(A) IMMEDIATE CAUSE

X HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/30/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/3/69

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 2 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

John J. Gowanlock, Inc.

ADDRESS

901 St.

23rd.

12/1/1902
Dear Sir,
I have the pleasure to inform you that
the same has been forwarded to you
by the same.

Yours truly,
J. H. [Signature]

Very respectfully,
J. H. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5542
BIRTH NO. 69 5542		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) BECK, ANNIE E		2. DATE AND HOUR OF DEATH 5-27-69 3-25 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 36 Franklin Square Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland , B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2640 York way 22		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-92	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME Not Known		
14. MOTHER'S MAIDEN NAME Not known		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		
16. SOCIAL SECURITY NO. 179-07-3473		17. INFORMANT Paul Beck 2640 Yorkway		
18. 41091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD & CHF		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 5-23-1969 to 5-27-1969 , that (I) (we) last saw the deceased alive on 5/27/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Surinder		23B. DATE SIGNED 5/27/69		23C. PHYSICIAN'S NAME (Type) SURINDER
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 29-69		24C. NAME OF CEMETERY or CREMATORY Shenberger's (Chapel) Cemetery
24D. LOCATION (City, town, or county) (State) Chancellor Twp York Co., Pa		25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		
25B. NAME OF REGISTRAR Lib C. Baker, R.D.		25C. NAME OF FUNERAL DIRECTOR James J. Hartenstein		

and the other side of the river

the river is very narrow

and the water is very shallow

and the current is very strong

the river is very narrow

the river is very narrow

and the water is very shallow

the river is very narrow

and the water is very shallow

the river is very narrow

and the water is very shallow

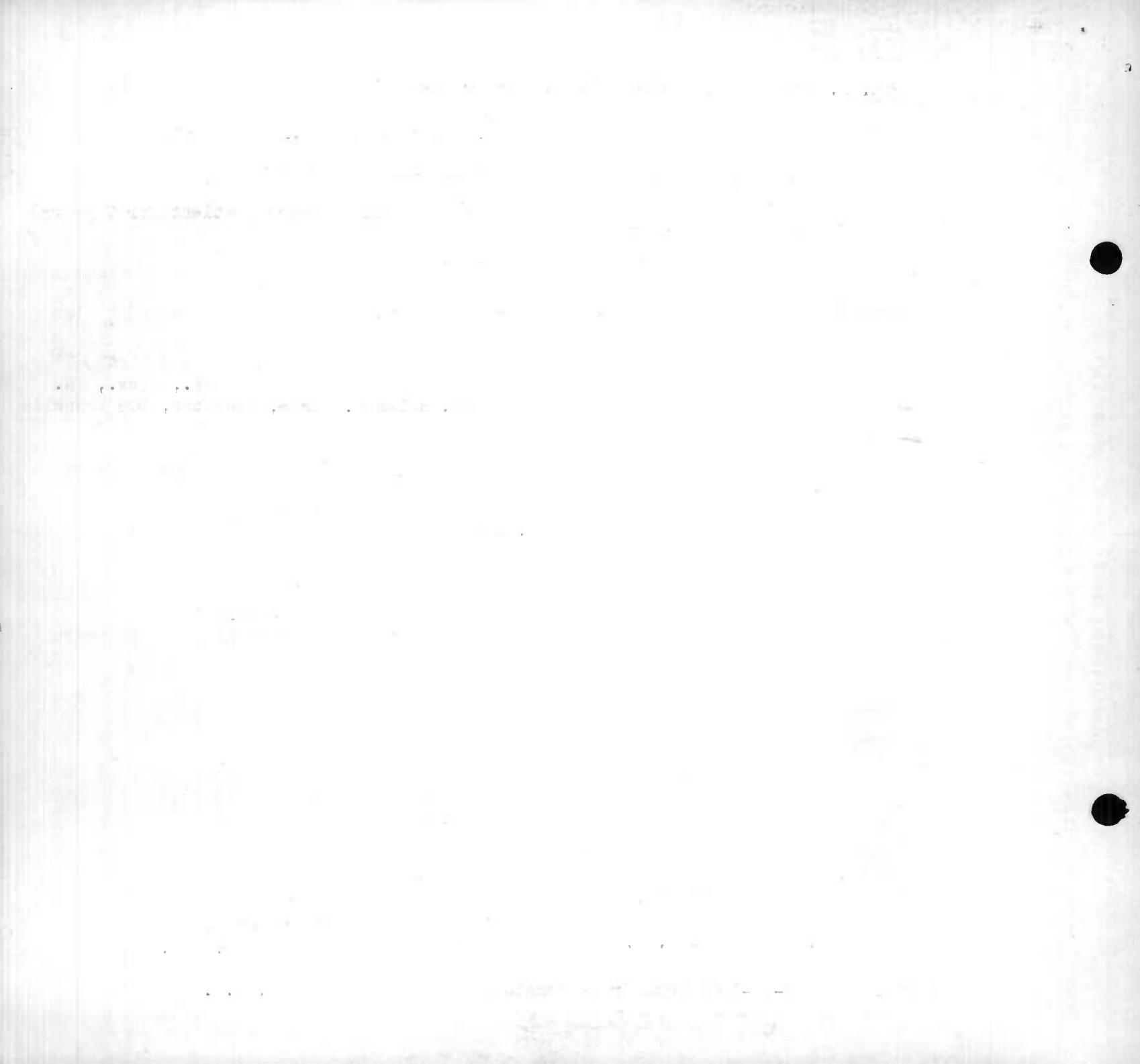
the river is very narrow

and the water is very shallow

the river is very narrow

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

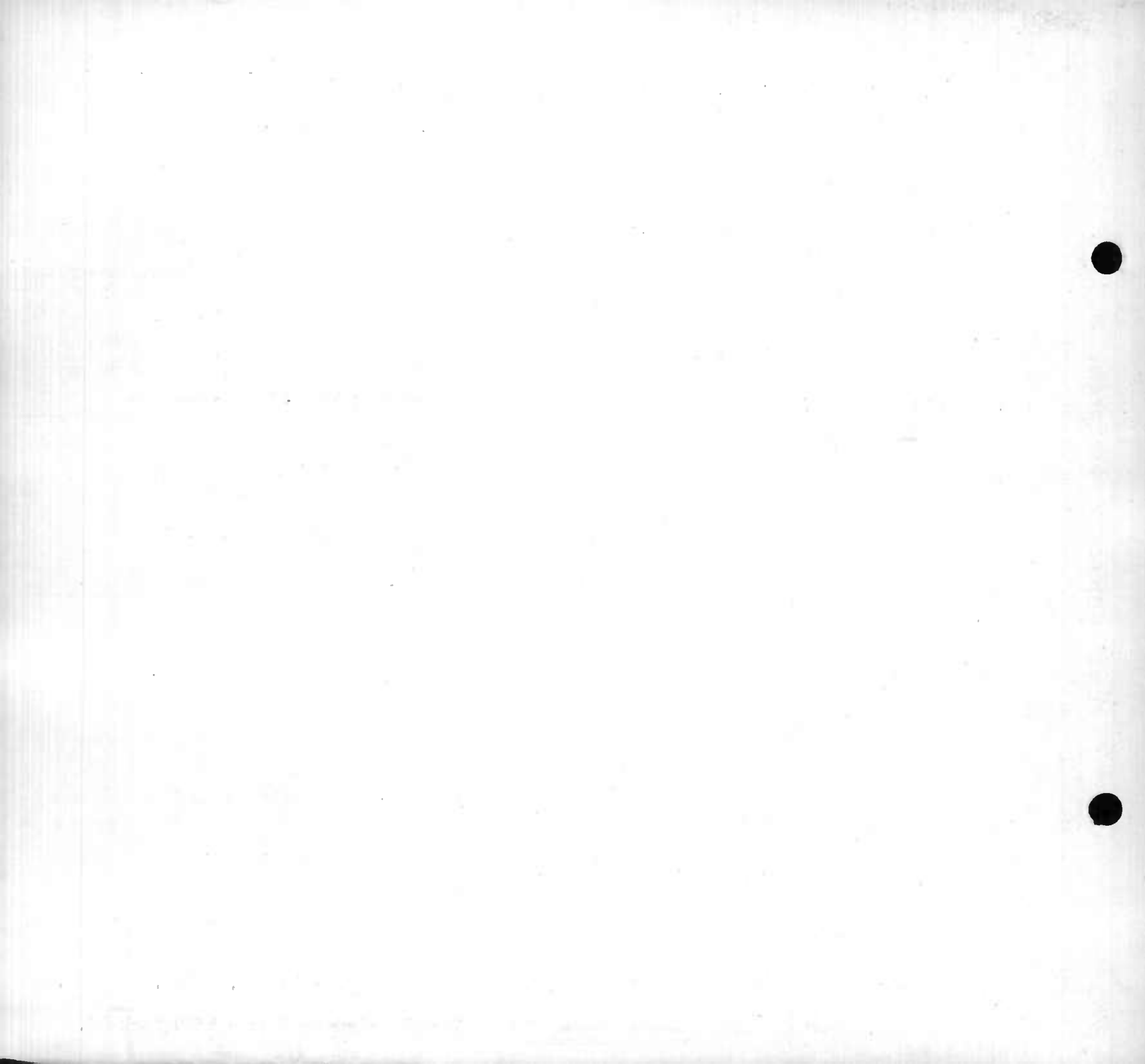
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5543	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mrs. M. Edith McGlue aka Edith Taylor McGlue		2. DATE AND HOUR OF DEATH May 29, 1969 4:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE District of Columbia B. COUNTY Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION 19 The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Washington D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female RACE White		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-15-1876 9. AGE (In years last birthday) 93	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Williamsport, Maryland	
13. FATHER'S NAME George Taylor		14. MOTHER'S MAIDEN NAME Mary Knave		12. CITIZEN OF WHAT COUNTRY? United States	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Helen M. Magee, Daughter, 309 Franklin St., Alex., Va.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) Chronic myocardial degeneration 6 years		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. General arteriosclerosis; arterial hypertension; diabetes mellitus ?		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic myocardial degeneration 6 years		(B) ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). arteriosclerosis		(C) Chronic Brain syndrome with cerebral		10 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 24, 1963 to May 29, 1969 , that (I) (we) lost saw the deceased alive on May 29, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter O. Jahrreiss, M.D.		23B. DATE SIGNED May 29, 1969		23C. PHYSICIAN'S NAME (Type) Walter O. Jahrreiss, M. D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-31-1969		24C. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Talber, M.D.		25C. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.	
24D. LOCATION Washington, D.C.		24E. ADDRESS 6100 Wabash Avenue, Balto., Md. 21215		24F. ADDRESS 6130 WISC. AVE., N. W. WASH., D. C. 20016	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

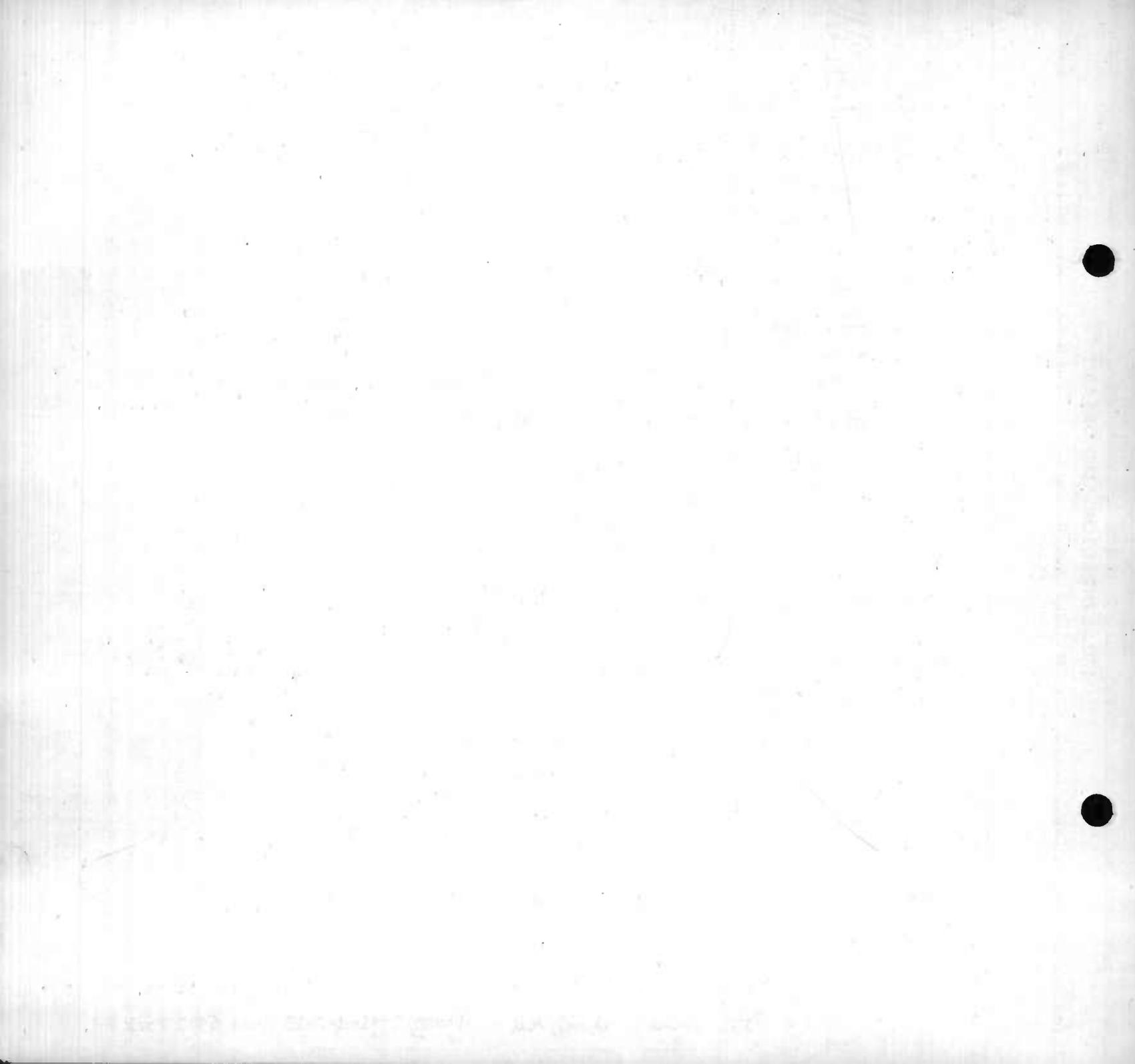
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5544	
69 5544 CERTIFICATE OF DEATH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) CHARLES B. FISHER			2. DATE AND HOUR OF DEATH 5/29/69 9⁰⁰ AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48			E. STREET AND NUMBER 5514 Ivanhoe Ave. 27-78		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/23	9. AGE (In years last birthday) 45	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME George A. Fisher			14. MOTHER'S MAIDEN NAME Alice Schneider		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 219-12-8530	17. INFORMANT ADDRESS Jeannette Fisher 5514 Ivanhoe Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 432.91 Cerebral edema			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular acc		
ANTECEDENT CAUSES			(B) Re-Thrombosis @ int. carotid an		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) occlusion (D) int. carotid an		
II			Pulmonary embolism		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 5/28/69	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED occ. R. int. carotid a.	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-21-1969 to 5/29 19 69 , that (I) (we) last saw the deceased alive on 5/29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D. DEGREE			23B. DATE SIGNED 5/29/69		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) K. S. DRITSAS		23D. ADDRESS 1114 ST. PAUL ST. BALTO Md 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5/31/69	24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	24D. LOCATION (City, town, or county) (State) Frederick Rd. Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969	25B. NAME OF REGISTRAR [Signature] M.D.	25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 5545				BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 69 5545			
1. NAME OF DECEASED (Type or Print) BACHMAN, ETTA J				2. DATE AND HOUR OF DEATH May 29 1969 10:30 A. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. 53-00							
FULL NAME OF HOSPITAL OR INSTITUTION Wm. Charles Br. Hospital 49 Wm. Charles St. Baltimore, Maryland				C. CITY OR TOWN Baltimore County				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 2 Over Ridge Court				8. DATE OF BIRTH Sept 29, 1884				9. AGE (In years, last birthday) 84 XXXXXX			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Herman Johnson				14. MOTHER'S MAIDEN NAME Hannah Johnson				17. INFORMANT Marjorie J. Bachman 2 Overridge Court Hospital Chart ADDRESS Balto., Md. 21210			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 216 32 7543D							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4/10/69 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arterio Sclerotic myocardial infarction				(B) DUE TO, OR AS A CONSEQUENCE OF: Arterio Sclerotic myocardial infarction							
(C).....											
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Anemia							
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 10, 1969 to May 29, 1969 , that (I) (we) last saw the deceased alive on May 29, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE DEOGRACIAS V. FAUSTINO, M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 5/29/69			
23C. PHYSICIAN'S NAME (Type) DEOGRACIAS V. FAUSTINO, M.D. DEGREE				23D. ADDRESS Wm. Charles Br. Hospital Baltimore, Maryland							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 5/31/69				24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery			
				24D. LOCATION (City, town, or county) Woodlawn Balto., Md.							
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 - 5546 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 5546

BIRTH NO.

1. NAME OF DECEASED
(Type of Print)

Roy - H Shannahan

2. DATE AND HOUR OF DEATH

5-29 - 69 1 5-15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
 8MG GEN HOSP
 6-24-69

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY
MD BALTO. 27-06

C. CITY OR TOWN

BALTO

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

E. STREET AND NUMBER

6201 PLYMOUTH RD

5. SEX

M

6. RACE

CAU

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

6-12-25

9. AGE (in years last birthday)

43

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SALESMAN

10B. KIND OF BUSINESS OR INDUSTRY

Auto PARTS

11. BIRTHPLACE (State or foreign country)

Balto. Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Edgar W. Shannahan

14. MOTHER'S MAIDEN NAME

Katherine Armstrong

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

yes WW 31

16. SOCIAL SECURITY NO.

219-18-9837

17. INFORMANT

Barbara J. Shannahan

ADDRESS

Same

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

CARCINOMA - Lung

(A) IMMEDIATE CAUSE Neurogenic tumor of right frontal

DUE TO, OR AS A CONSEQUENCE OF:

lobe (excised in 1953) with extension through the right frontal (2 years duration) bone and cervical and thoracic metastases - 6 mos. duration

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

NEVER - SAW PT ALIVE

23A. SIGNATURE

Daniel H White MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

5-15-69

23C. PHYSICIAN'S NAME (Type)

DANIEL H WHITE MD

23D. ADDRESS

MD. GEN. HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

6-2-69

24C. NAME OF CEMETERY OR CREMATORY

Balto. National Cemetery Baltimore Maryland

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 2 1969

25B. NAME OF REGISTRAR

Robert E. Taber, M.D.

25C. FUNERAL DIRECTOR

Chas F Evans, Son 8802 Harford Rd

ADDRESS

Letter from Maryland General Hospital
6-24-69 M.H.

FUNERAL DIRECTOR: IMPORTANT

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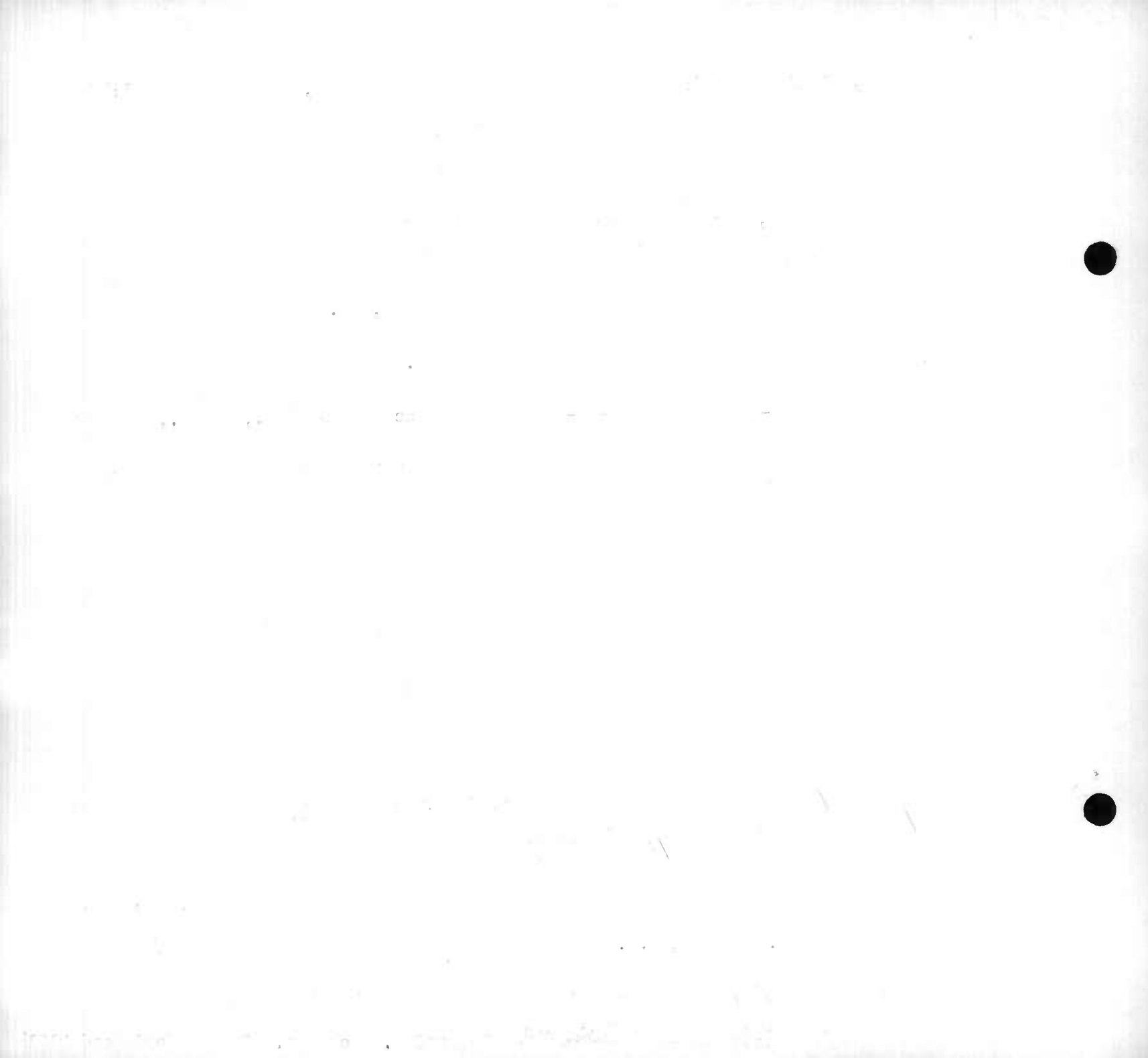
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 5547</u>
69 5547		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Reverend Aloysius E. Bernhard</u>		2. DATE AND HOUR OF DEATH <u>5-27-69</u> <u>7:15 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Mercy Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>17-01</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>600 N. PACA ST</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-09-04</u>	9. AGE (In years last birthday) <u>64</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Religious</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>
13. FATHER'S NAME <u>PAUL Bernhard</u>		14. MOTHER'S MAIDEN NAME <u>MARY DALY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Fr. John R. Sullivan</u>
				ADDRESS <u>5408 Roland Ave. Balto. Md.</u>
18. <u>440.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CEREBRAL VASCULAR INSUFFICIENCY</u>				
19A. DATE OF OPERATION <u>4-22-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>THORACOTOMY</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>4-1</u> 19 <u>67</u> to <u>5-27</u> 19 <u>69</u> that <u>(H)</u> (we) last saw the deceased alive on <u>5-27</u> 19 <u>69</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Salvatore R. Donohue MD</u>		23B. DATE SIGNED <u>27 May 69</u>		
23C. PHYSICIAN'S NAME (Type) <u>SALVATORE R. DONOHUE MD</u>		23D. ADDRESS <u>MERCY HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5/30/69</u>	24C. NAME of CEMETERY or CREMATORY <u>St. Charles College Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1969</u>	25B. NAME OF REGISTRAR <u>Robert E. Fisher, RPA</u>	25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc.</u>		ADDRESS <u>Balto. Md.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LOVE, William Francis		2. DATE AND HOUR OF DEATH May 28, 1969 1:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-48		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 5803 The Alameda	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/95	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asbestos worker		10B. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jerome Love		14. MOTHER'S MAIDEN NAME Mary J. Dean	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/25/17 - 6/2/19		16. SOCIAL SECURITY NO. 216-07-7980		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. 1990 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II			
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from April May 27 19 69 to May 28 19 69 that (I) (we) last saw the deceased alive on May 28 19 69 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE RALPH H. TWINING, M.D.	
23B. DATE SIGNED May 28, 1969		23C. PHYSICIAN'S NAME (Type) RALPH H. TWINING, M.D.		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31/69		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR Leopard J. Buek Inc.		25D. ADDRESS 5305 Harford Road 21218			

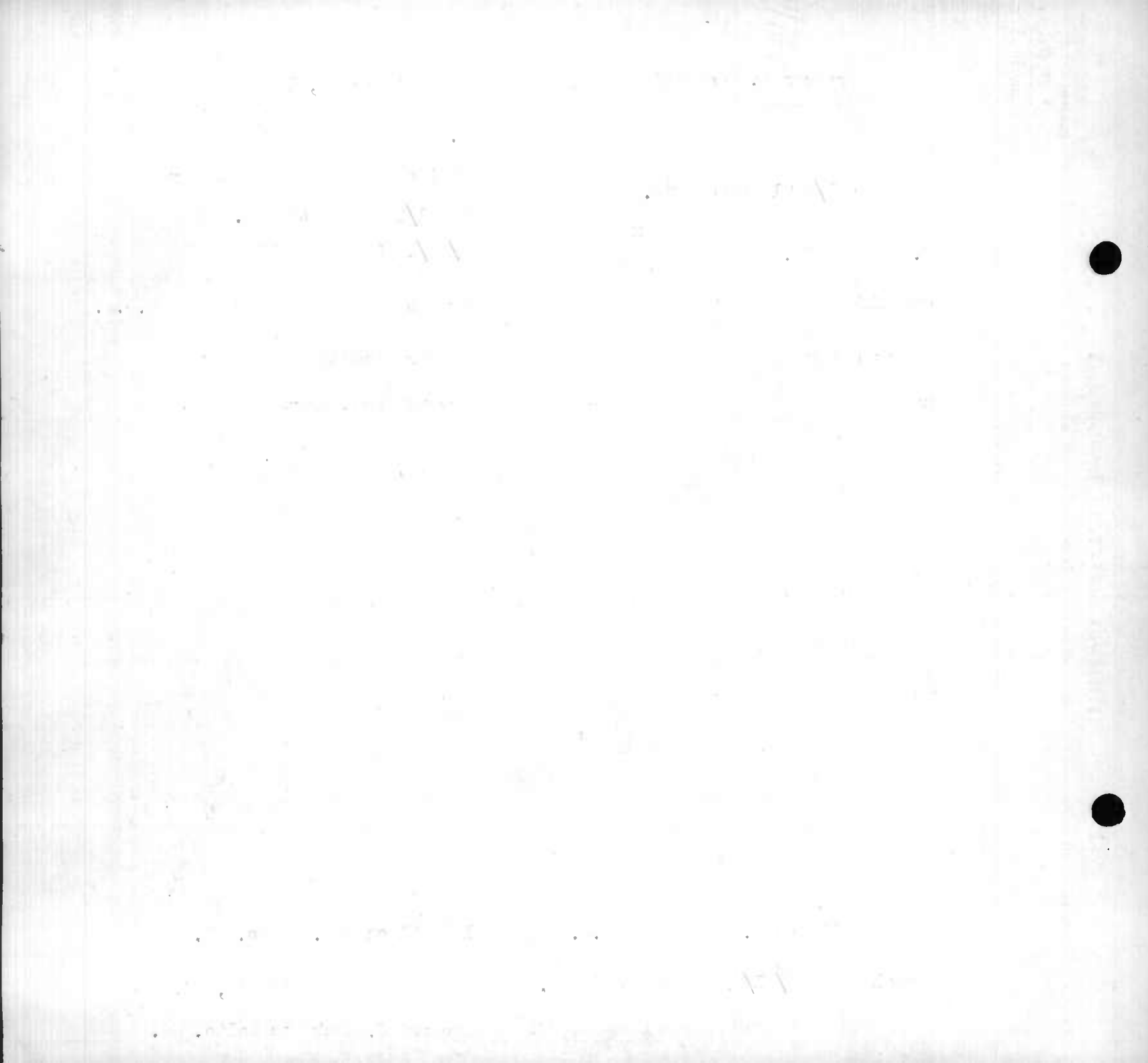


FUNERAL DIRECTOR: IMPORTANT

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69 5549 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH REG. NO. 69 5549

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Frances A. Woodward		2. DATE AND HOUR OF DEATH May 28, 1969	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 27-47			
FULL NAME OF HOSPITAL OR INSTITUTION 2700 1/2 Fleetwood Ave.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2700 1/2 Fleetwood Ave.			
5. SEX F.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/10/1892	9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Adam Sapp		14. MOTHER'S MAIDEN NAME Mary Schmur Schnur			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-01-5740		17. INFORMANT Merchant Woodward-same	
18. 4/10.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Coronary ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Edema Legs Atherosclerotic Vascular Disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 7-10	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 4 - 1969 to May 28 1969 , that (I) was last saw the deceased alive on May 28 1969 and that in (my) and opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE William G. Geyer		23B. PHYSICIAN'S NAME (Type) William G. Geyer M.D.		23C. ADDRESS 156 Milton Ave. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31/69		24C. NAME OF CEMETERY or CREMATORY Parkwood Cem.	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR John E. Taylor M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Balto. Md.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		24E. ADDRESS			



H-163

69 5550 BALTIMORE CITY HEALTH DEPARTMENT

X 69 5550

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED Joseph Coburn (Type or Print) JOSEPH COBURN HUBBARD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 5 27 69 1:15 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour May 27, 1969 1:15 p.m.	
6. SEX Male 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 53-00 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 5/5/1917 10. AGE (In years lost birthday) 52 11. BIRTHPLACE (State or foreign country) Md.		E. STREET AND NUMBER 231 Ridge Ave.	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Joseph Hubbard	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Eng.		15. MOTHER'S MAIDEN NAME Daisy Moore	
14B. KIND OF BUSINESS OR INDUSTRY Balto. G. & E. CO.		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 2 12-05-4730		18. INFORMANT Mildred Hubbard ADDRESS same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 21		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED May 28, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/69	
24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Pk.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md.	

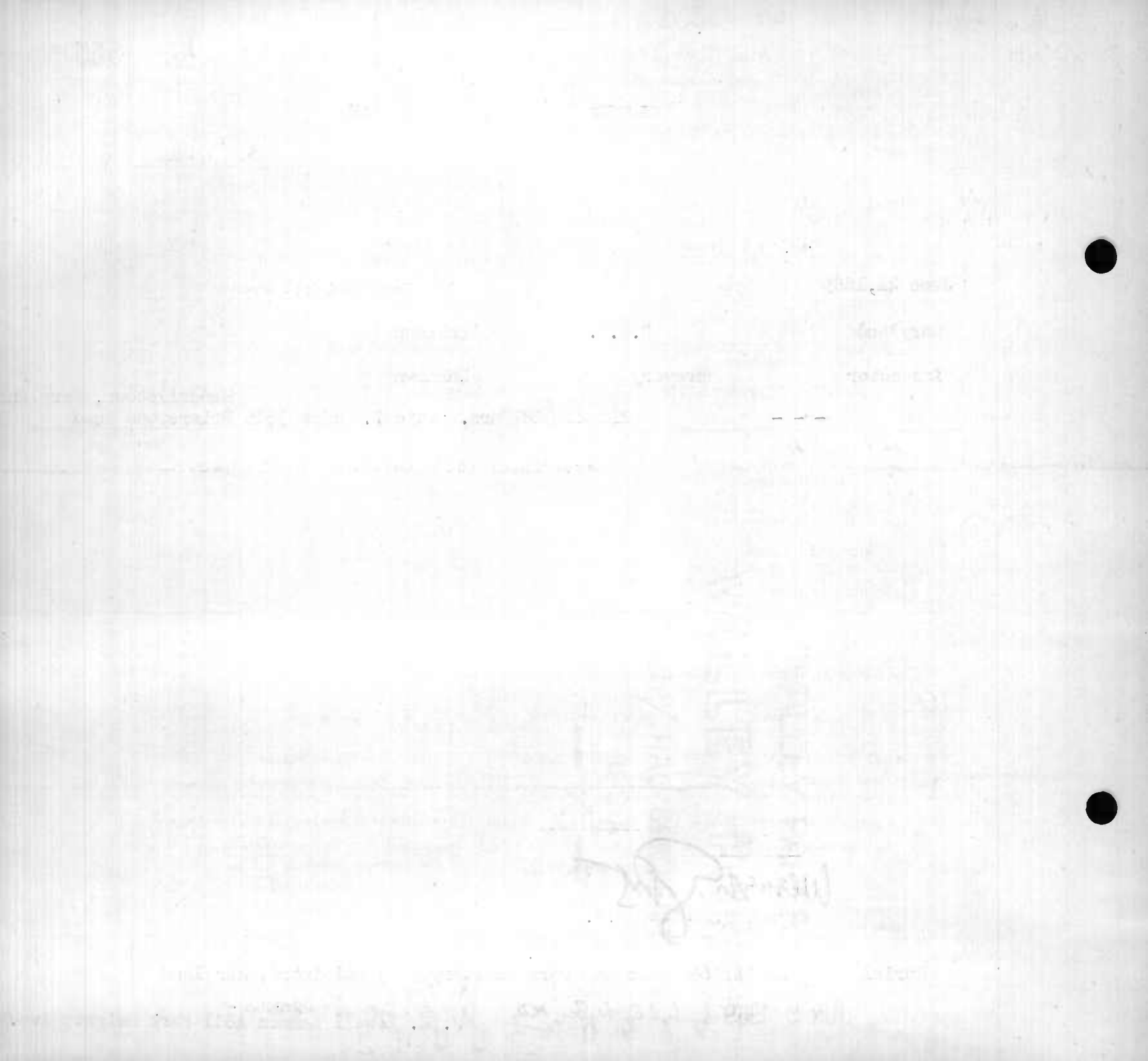
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K-560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5551

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT KINNIER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> May 26, 1969 8:25 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour May 26, 1969 8:25 P.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-16	
9. DATE OF BIRTH June 21, 1885		10. AGE (In years lost birthday) 83	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. STREET AND NUMBER 4713 Park Heights Avenue	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		14B. KIND OF BUSINESS OR INDUSTRY Brewery	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 218 22 0287		18. INFORMANT Mrs. Sadie L. Grimm	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 412.4		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 5/27/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 29 MAY 69	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR J. E. Lowell Lemmon		ADDRESS 4611 Park Heights Ave.	



FUNERAL DIRECTOR: IMPORTANT

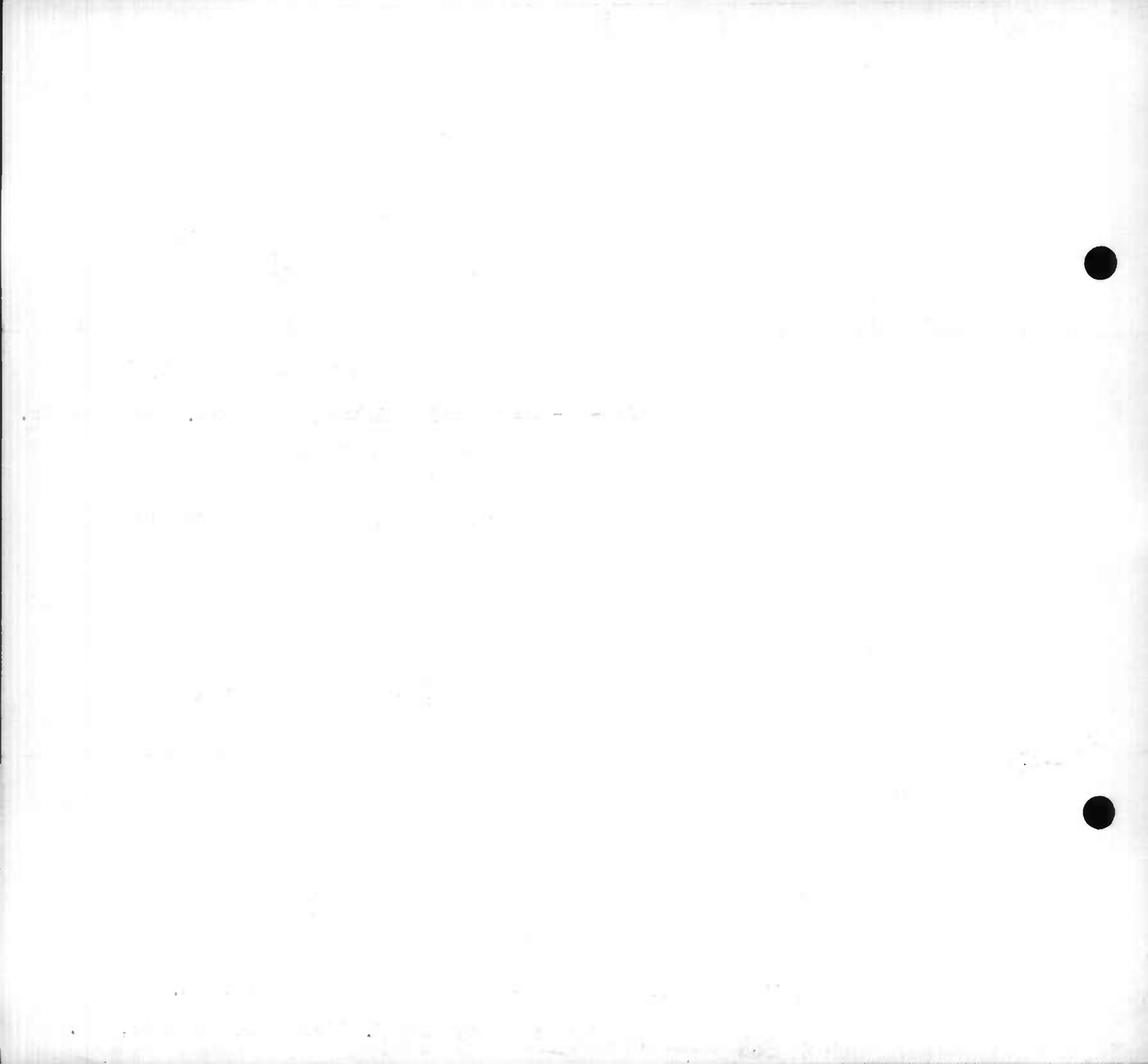
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 5552 CERTIFICATE OF DEATH

REG. NO. 69 5552

BIRTH NO. 69 5552		69 5552	
1. NAME OF DECEASED (Type or Print) <u>Bessie Dillard</u>		2. DATE AND HOUR OF DEATH <u>5-27-69</u> <u>9:15 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Maryland Gen. Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>25-05</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland Gen. Hosp.</u>		C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>3816 St. Margaret ST.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bakery Helper</u>		8. DATE OF BIRTH <u>9-25-17</u> 9. AGE (In years last birthday) <u>51</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO., Md.</u>	
13. FATHER'S NAME <u>Floyd Tester</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>Ethel Livingston Lovett</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>216-16-6310</u>		17. INFORMANT ADDRESS <u>Ennis Dillard 3816 St. Margaret St.</u>	
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EDEMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARTERIOSCLEROTIC HEART DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-22</u> <u>1969</u> to <u>9-27</u> <u>1969</u> that (I) (we) last saw the deceased alive on <u>9-27</u> <u>1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Delfa Gomez-Dumaran, M.D.</u>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Delfa Gomez-Dumaran, M.D.</u>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/31/69</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Raymond C. Fink</u>	
25C. FUNERAL DIRECTOR ADDRESS <u>Glen Burnie, Md.</u>			

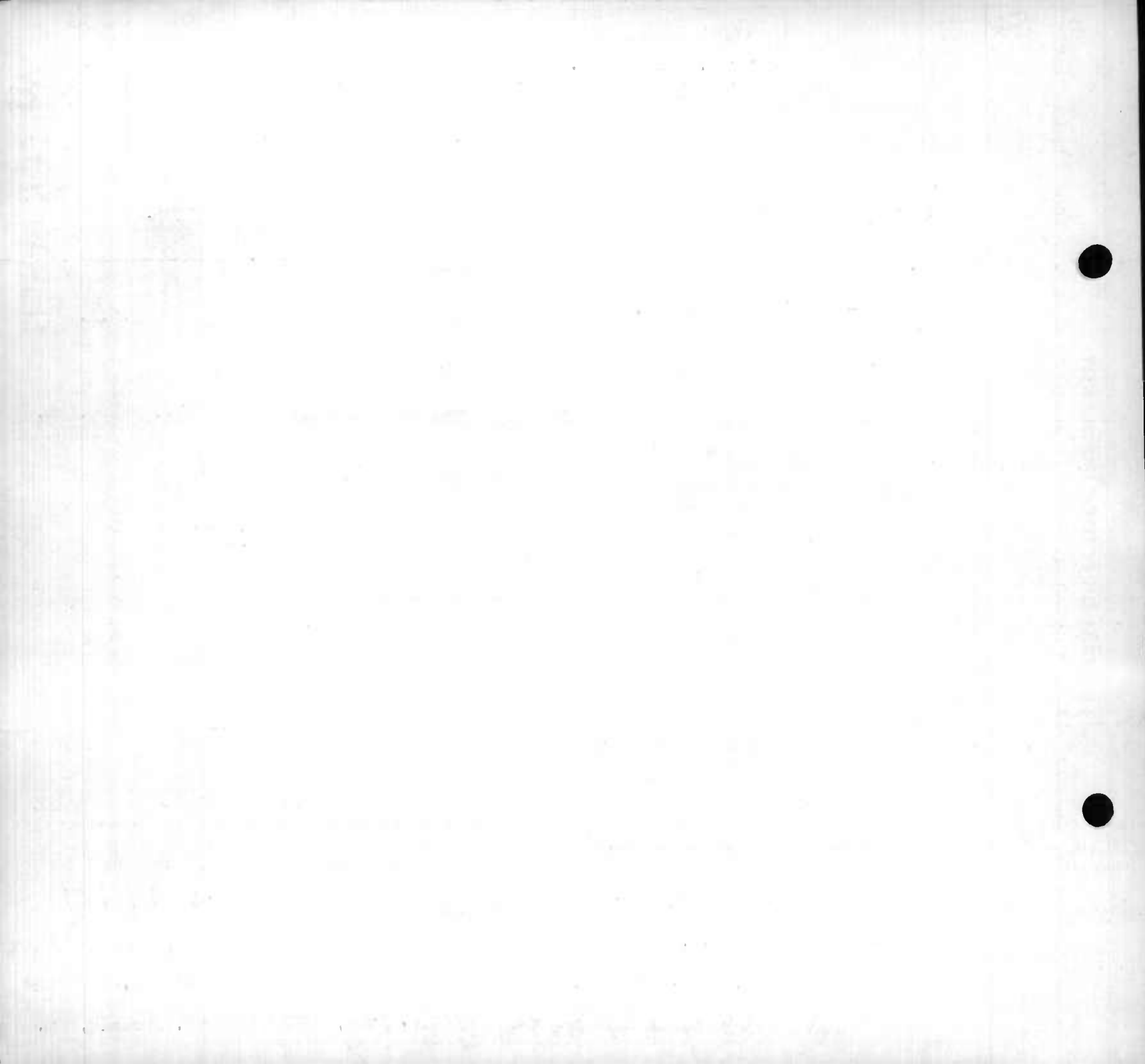
JUN 2 1969



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5553	
BIRTH NO.		1. NAME OF DECEASED <u>Larkin L. Niemyer Sr.</u>		2. DATE AND HOUR OF DEATH <u>5-27-69 11:50 PM</u>	
(Type or Print) <u>NIE MYER</u>		<u>LARKIN</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND 21224</u>			A. STATE <u>MARYLAND</u>		B. COUNTY <u>BALTIMORE</u>
			C. CITY OR TOWN <u>Fort Howard</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <u>HOWARD & BAYSIDE AVENUE 21052</u>					
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-04</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman - Bethlehem Steel Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>LOUIS H. NIEMYER</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN PFEIFFER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-9230</u>		17. INFORMANT <u>BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.</u>	
18. <u>410.9 I</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			<u>myocardial infarction</u> <u>cardiac arrest</u>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>5-27-69</u> to <u>5-27-69</u> , that (1) (we) last saw the deceased alive on <u>5-27-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Chris Stucky M.D.</u>				23B. DATE SIGNED <u>5-27-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. CHRIS STUCKY M.D.</u>				23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/31/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1969</u>		25B. NAME OF REGISTRAR <u>John J. Duda</u>		25C. FUNERAL DIRECTOR ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

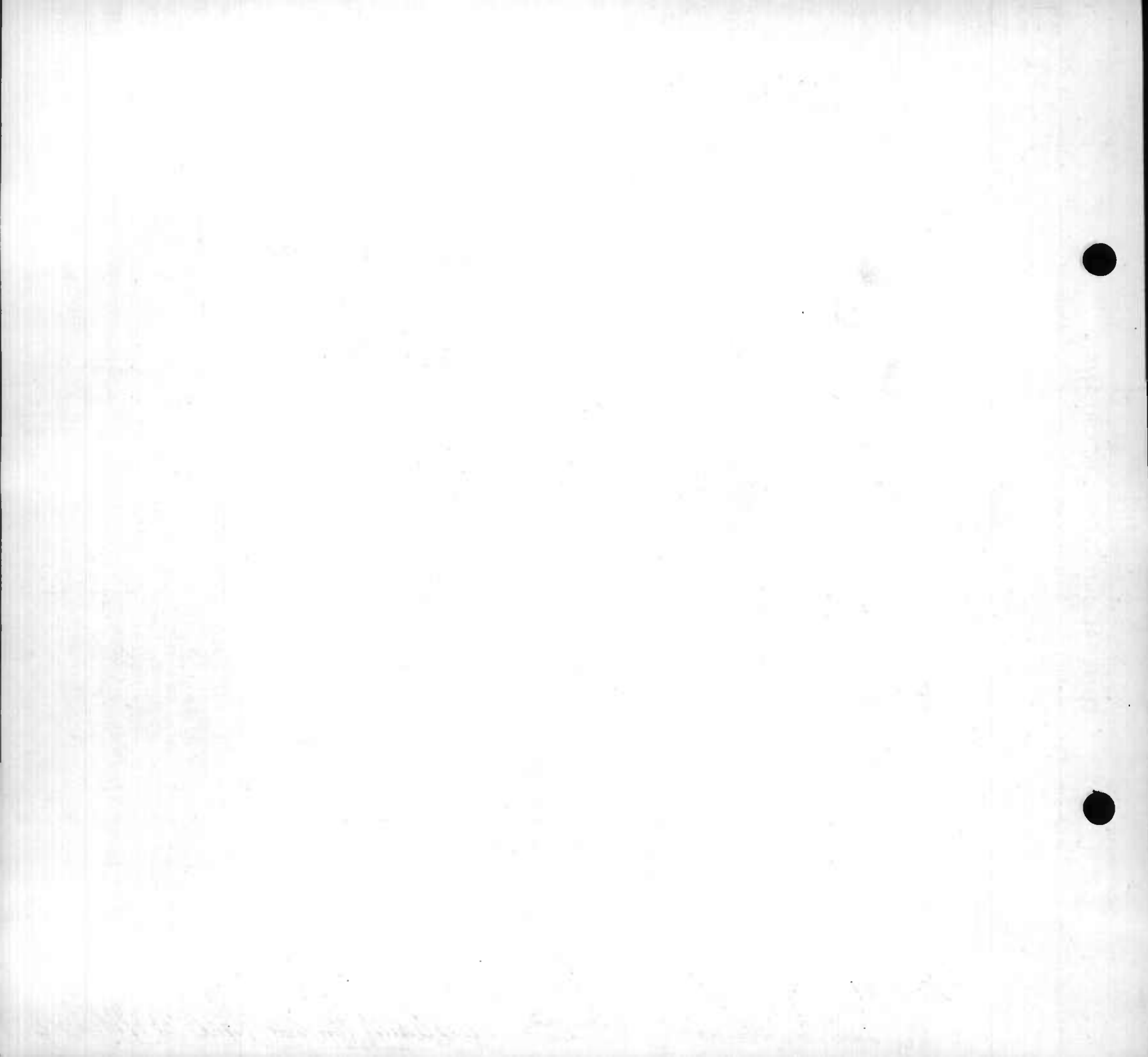
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 5554</u>
BIRTH NO. <u>69 5554</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>YELLOWDY, BLANCH</u>		2. DATE AND HOUR OF DEATH <u>6.1.69</u> <u>3:10 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>36 Franklin Square Hospital</u>		A. STATE <u>Maryland</u>		
		B. COUNTY <u>18-02</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1209 W. Lexington St.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1914</u>	9. AGE (In years last birthday) <u>55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>M.C.</u>
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Vernon Yellowdy</u>
				ADDRESS <u>803 N. Fulton Ave</u>
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>C.V.A.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1. This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>?</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>5/29/69</u> 19 <u>69</u> to <u>6/1/69</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6-1-</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Surinder</u>		MD. DEGREE <u>MD.</u>		23B. DATE SIGNED <u>6/1/69</u>
23C. PHYSICIAN'S NAME (Type) <u>SURINDER</u>		23D. ADDRESS <u>Franklin Square Hospital</u>		
24A. BURIAL - CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/4/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>McAuliffe Cem.</u>
24D. LOCATION <u>Balto Md.</u>		(City, town or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>William J. W. Kane</u>
				ADDRESS <u>319 N. Schroeder St.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 5555
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH COOPER		2. DATE AND HOUR OF DEATH 5-31-69 1:00 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 19-01 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1637 FAYETTE ST. 23		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUN 24 1895	9. AGE (In years last birthday) 73 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) FREDERICK, M.D.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DUFF COOPER		
14. MOTHER'S MAIDEN NAME ROSE COOPER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. NO		17. INFORMANT UTAI RUANGWIT, M.D. FRANKLIN SQUARE HOSP.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 427.2 I CAUSE OF DEATH CARDIO RESPIRATORY ARREST. RIGHT MIDDLE LOBE PNEUMONIA 12 days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) NO
21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21G. TIME OF INJURY (Approx.)		21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21I. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 5-19-69 to 5-31-69 , that (I) (we) last saw the deceased alive on 5-31-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Utai Ruangwit, M.D.		23B. DATE SIGNED 5-31-69		23C. PHYSICIAN'S NAME (Type) UTAI RUANGWIT, M.D.
23D. ADDRESS FRANKLIN SQUARE HOSPITAL		23E. DATE REC'D BY HEALTH DEPT. JUN 2 1969		
23F. NAME OF REGISTRAR James E. Fisher, M.D.		23G. FUNERAL DIRECTOR Williams Funeral Home		
23H. ADDRESS 319 N. ...		23I. DATE OF BURIAL 6/3/69		
23J. NAME OF CEMETERY OR CREMATORY Greenwood		23K. LOCATION (City, town, or county) (State) Baltimore, Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
69 5556		X	
BIRTH NO.		REG. NO. 69 5556	
1. NAME OF DECEASED (Type or Print) Miss Helen Fidelis Shannon		2. DATE AND HOUR OF DEATH 6-1-69 8:15 A.M. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Jenkins Memorial Hospital 1000 S. Caton Ave. Baltimore, Md. 21229		A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN Lutherville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 4, 1893	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11. BIRTHPLACE (State or foreign country) Hallstead, Pa.	
13. FATHER'S NAME Thomas W. Shannon		14. MOTHER'S MAIDEN NAME Margaret Cahill	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 577-38-5040	
17. INFORMANT ADDRESS Jenkins Memorial Hospital 1000 S. Caton Ave.			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypothermia 2 hrs (B) Bacteremia 24 hrs (C) Felty's Syndrome years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Severe Rheumatoid Arthritis 20-2	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (H) (this hospital) attended the deceased from 10/6 to 10/7 to 6/1/1969, that (H) (we) last saw the deceased alive on 6/1/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.		20A. AUTOPSY? (Yes or No)	
23A. SIGNATURE J. Raymond Gladue		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
23C. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.		23B. DATE SIGNED 6/1/69	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. NAME OF CEMETERY OR CREMATORY	
24C. DATE		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-3661		69 5557		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 5557	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
				BITTORF, William A.				5/29/69 9:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				A. STATE			
FULL NAME OF HOSPITAL OR INSTITUTION				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY			
UNION MEMORIAL HOSP				MD.				Queen Anne 67-00			
44				C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
				CHESTER				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER				CASTLE MARINA							
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
m		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10/20/90		78			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
RET				AUTO				MD			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
US				AUGUST BITTORF				EMILY WINKLEMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No				213-03-5490				MRS. PEARL BITTORF			
ADDRESS				SAME							
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CVA				6 d.			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:							
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
5/25/69				RESP FLR				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from				5/21/69				19 to 5/29 19 69			
that (I) (we) last saw the deceased alive on				5/29/				19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED							
Charles S. Brown M.D.				5/29/69							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
CHARLES S. BROWN M.D.				UNION MEMORIAL HOSP							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME of CEMETERY or CREMATORY			
Burial				June 2, 1969				Loudon Park Cemetery			
24D. LOCATION (City, town, or county) (State)				24E. DATE REC'D BY HEALTH DEPT.				24F. NAME OF REGISTRAR			
Baltimore Md.				JUN 2 1969				E. Haber, M.D.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
								HENRY SANDER & SONS, INC			
								Baltimore Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5558 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH REG. NO. 69 5558

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Berkeley Virginia		2. DATE AND HOUR OF DEATH 5-29-69 7:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 91 Keswick				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER 700 W. 40th St. 21211	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX F	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-1910	9. AGE (In years last birthday) 58 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WARREN SEWELL		14. MOTHER'S MAIDEN NAME Marie Weber	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 213-034390		17. INFORMANT M. J. Humble, R.N. ADDRESS Keswick	
18. 340X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cardiac arrhythmia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Aspiration anoxia Multiple sclerosis		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrhythmia (B) DUE TO, OR AS A CONSEQUENCE OF: Aspiration anoxia (C) Multiple sclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instantaneous 8 hours 720 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 1/2/69 19 to 5/29/69 19 that the (we) last saw the deceased alive on 5/29/69 19 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE W.B. Daniels, Jr. M.D.		23B. DATE SIGNED 5/29/69		23C. PHYSICIAN'S NAME (Type) W. B. DANIELS, Jr.	
23D. ADDRESS Keswick, Baltimore, Md., 21211					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE June 2, 1969		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) Pikesville Md.		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. ADDRESS Baltimore Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) WILLIAM PARKER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 29, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour May 29, 1969 2:44 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-05	
9. DATE OF BIRTH Feb 23 1925		10. AGE (In years last birthday) 44	
11. BIRTHPLACE (State or foreign country) Cecil County Md.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Hennetta Roberts		16. INFORMANT Claybelle Parker	
17. SOCIAL SECURITY NO.		ADDRESS 2317 Harford Ave	

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) E9661X		CAUSE OF DEATH (A) IMMEDIATE CAUSE Stab wounds of chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2nd fl. apt. 2306 Fleet Street	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 5-29-69 2:20 A. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed during altercation	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Charles S. Springate, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
			DATE SIGNED May 29, 1969		

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 4/69		24C. NAME of CEMETERY or CREMATORY Baltimore Natl Cem		24D. LOCATION (City, town or county) (State) 5501 Fredrick Ave	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Fahey, M.D.		25C. FUNERAL DIRECTOR Yves P. Elchison		ADDRESS 1129 N. Carroll St	

2011/11/11

2011/11/11

2011/11/11

2011/11/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 5560
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Simon Harris</i>		2. DATE AND HOUR OF DEATH <i>May 26, 1969</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>10-02</i>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns Hopkins Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>807 Aisquith St.</i>			
5. SEX <i>Male</i>	6. RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 29, 1894</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Portsmouth Va.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>David Harris</i>		14. MOTHER'S MAIDEN NAME <i>Sarah ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Edith Harris</i>	
				ADDRESS <i>807 Aisquith St</i>	
18. <i>412.21</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertensive Cardiovascular Disease</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>arteriosclerosis</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 1966</i> 19 to <i>May</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>March 8</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.					
23A. SIGNATURE <i>Jesse T. Holmes M.D.</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5/29/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Jesse T. Holmes M.D.</i>		23D. ADDRESS <i>568 E North Ave.</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>May 31, 1969</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Arbutus md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 2 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Frank E. Jackson</i>		25D. ADDRESS <i>7129 N. Caroline St</i>			

10/10/10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) JAMES LITTLE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 6 1 69 1:35 a. m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1430 E. Lanvale St.		3. DATE PRONOUNCED DEAD Month Day Year June 1, 1969 1:35 a. m.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH April 4, 1897		10. AGE (In years last birthday) 72	
11. BIRTHPLACE (State or foreign country) Wadsworth N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank Little		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Steel Worker	
15. MOTHER'S MAIDEN NAME Ellen McCray		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes	
17. SOCIAL SECURITY NO.		18. INFORMANT Maggie Little	
19. ADDRESS 1430 E. Lanvale St.		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 412.4	

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	

20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED June 1, 1969	

24A. BURIAL CREMATION, REMOVAL (Specify) Removal	24B. DATE June 6/69	24C. NAME of CEMETERY or CREMATORY Wadsworth N. Carolina	24D. LOCATION (City, town, or county) (State) 11297 N. Carolina St
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR Zach T. Ellickson	ADDRESS

Sept 1877
William W. C.
John W. C.
J. W. C.

Frank L. C.
John W. C.
W. W. C.

James J. C.

William W. C.
John W. C.

1
E-450

69 5562 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5562

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PERCY ELAM		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 29, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 347 East 21st Street		3. DATE PRONOUNCED DEAD Month Day Year Hour May 29, 1969 2:30 A.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 12-04			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH Aug 27, 1924		10. AGE (In years last birthday) 48	E. STREET AND NUMBER 347 East 21st Street
11. BIRTHPLACE (State or foreign country) Charlotte City		12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME William Elam
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed below		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Essie Thompson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Minnie Elam ADDRESS 347 E 21st St	
19. CAUSE OF DEATH 486 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED May 29, 1969 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 4/69	
24C. NAME OF CEMETERY or CREMATORY Balti. National Cem.		24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1969		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.	
25C. FUNERAL DIRECTOR Walter E. Elchman		25D. ADDRESS 1129 N. Caroline St	

1000

WALKER & CO.

NEW YORK

James J. Walker & Co. 220 Broadway
New York City

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-412		69 5563		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 5563			
BIRTH NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
				SILVIUS, JACOB F				5-21-69 12:15P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND Howard Co. 63-00							
ST. AGNES HOSPITAL ; WILKENS & CATON BALTIMORE, MD. 21228				C. CITY OR TOWN ELLICOTT CITY				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 3760 ST. PAUL ST. #21043							
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-06	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY CARPENTER		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOSEPH SILVIOS DEC 'D				14. MOTHER'S MAIDEN NAME AMANDA TUSSING DEC 'D							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 218-05-7805		17. INFORMANT ST. AGNES RECORDS ROOM WILKENS & CATON					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the Lung & Metastasis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (X) (this hospital) attended the deceased from 5-19-1969 to 5-21-1969 that (X) (we) last saw the deceased alive on 5-21-1969 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.											
23A. SIGNATURE Adolfo Alonso				23B. DATE SIGNED 05 21 69							
23C. PHYSICIAN'S NAME (Type) ADOLFO ALONSO				23D. ADDRESS ST AGNES HOSP. BALTO MD 21229							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5-24-69		24C. NAME of CEMETERY or CREMATORY Good Shepherd		24D. LOCATION (City, town, or county) (State) Ellicott City, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 3 1969		25B. NAME OF REGISTRAR Joseph E. Barber, M.D.		25C. FUNERAL DIRECTOR Eugene B. Slack		ADDRESS Ellicott City, Md.					



53-59-98 JD

F-562

00 0564

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5564

BIRTH NO.		1. NAME OF DECEASED (Type or Print) RHOVA TAMRES		2. DATE AND HOUR OF DEATH 5:35 P.M. May 27 1969 5:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-98		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE, MD. #21224		E. STREET AND NUMBER 3503 SPAULDING AVE.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX FEMALE	7. RACE WHITE	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 10-15-37	10. AGE (In years last birthday) 31	11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH HOLZMAN		14. MOTHER'S MAIDEN NAME BESSIE WOODEN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. AVRUM TAMRES, 3503 SPAULDING AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 446.21		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Renal Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mo.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Membranous Glomerulonephritis 2y.		(C) DUE TO, OR AS A CONSEQUENCE OF: Collagen Vascular Disease of Indefinite Nature 2y.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Resolved KABBISILLA SEPTICEMIA		2 weeks	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (my) (this hospital) attended the deceased from April 30 1969 to May 27 1969 , that (we) last saw the deceased alive on May 27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE John E. Young		23B. DATE SIGNED May 27, 1969		23C. PHYSICIAN'S NAME (Type) JOHN E. YOUNG	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-28-69		24C. NAME OF CEMETERY or CREMATORY BETH YEHUDA ANSHE KURLANDER	
25A. DATE REC'D BY HEALTH DEPT. JUN 3 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SQL LEVINSON, & BROS., 6010 REISTERSTOWN ROAD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

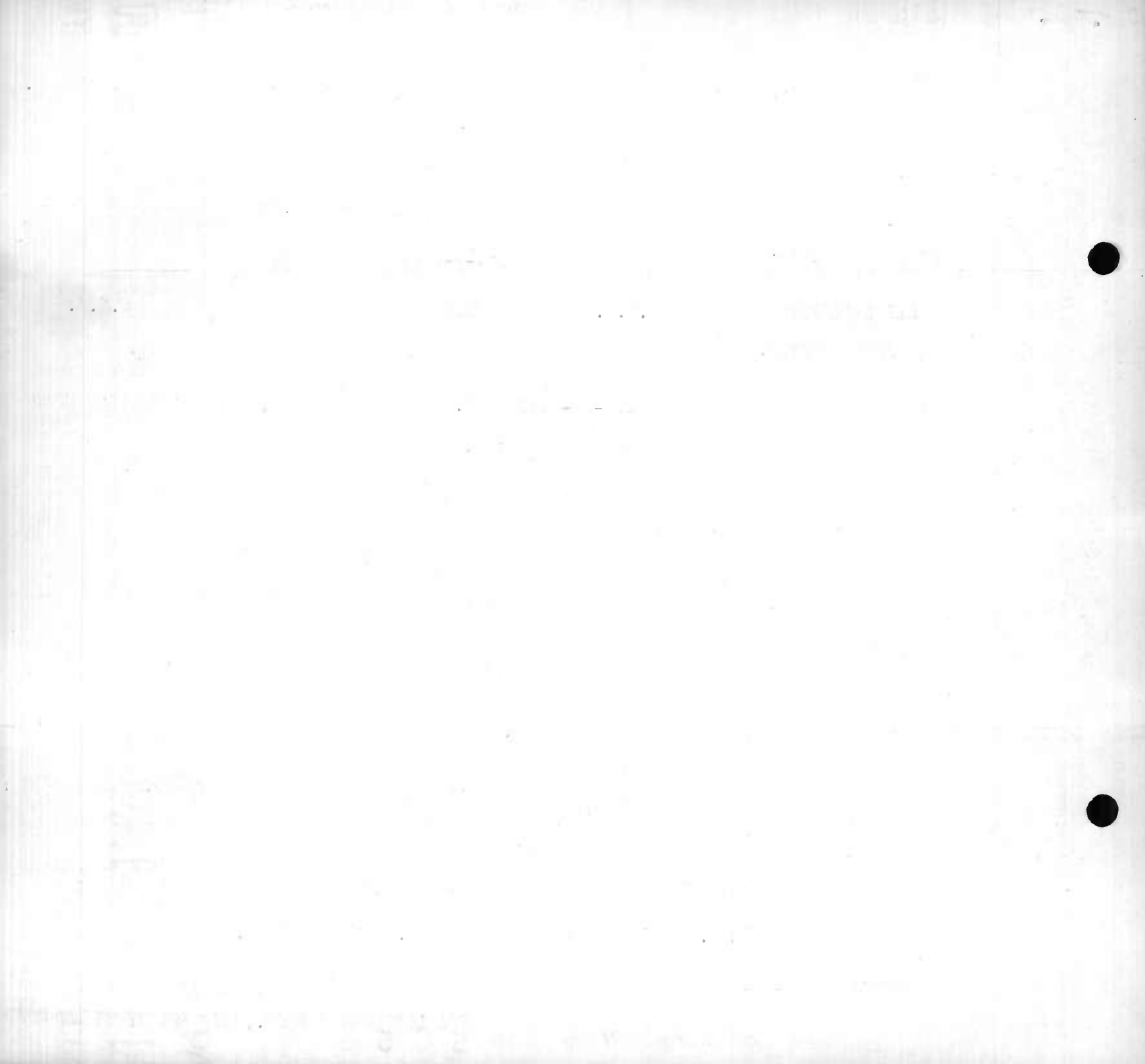
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

Ref: 2-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

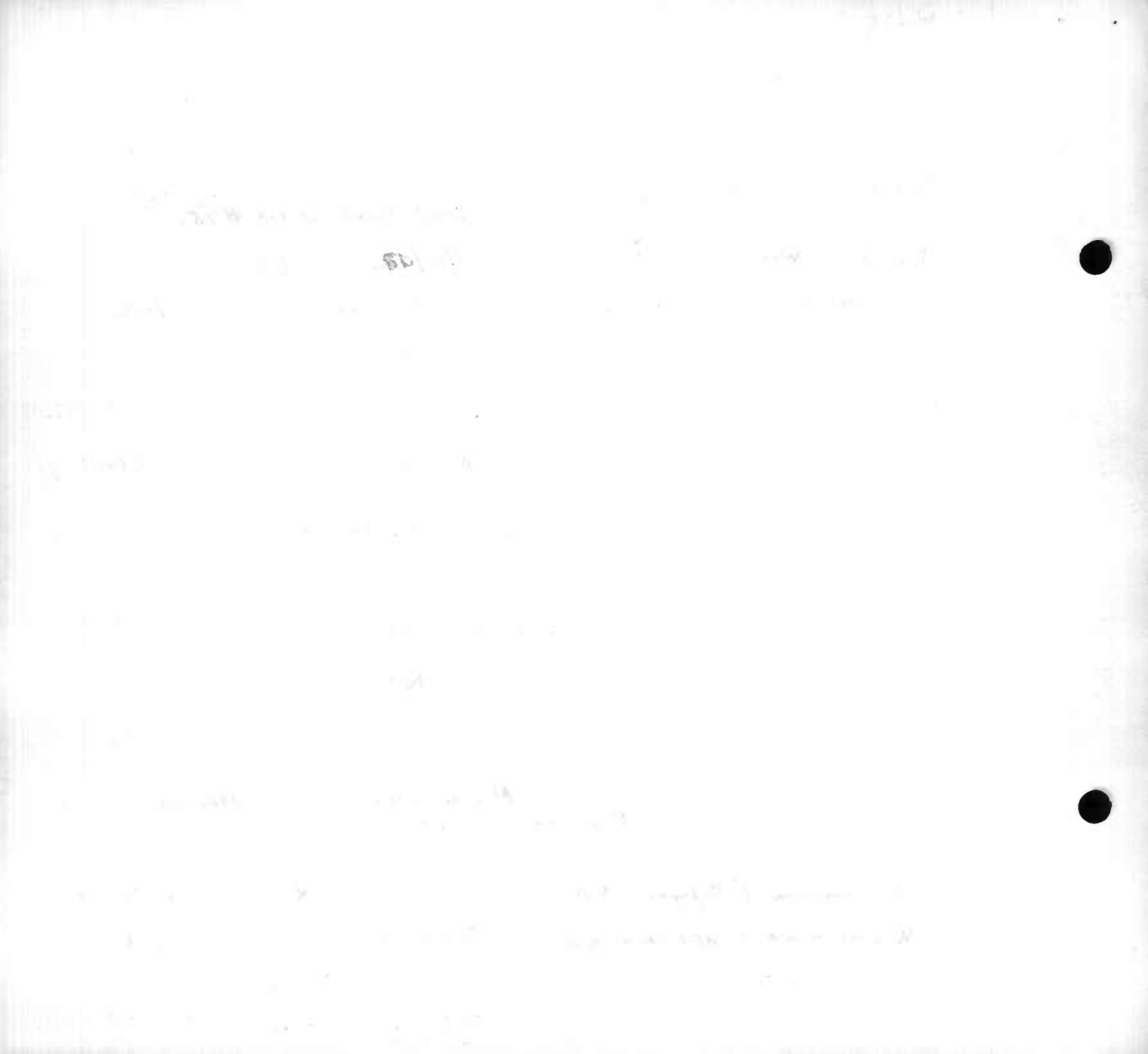
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5565 | |
|---|----------------------|---|---|---|--|
| B-523 | | 69 5565 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) DAVID BOMSTEIN | | | | | |
| 2. DATE AND HOUR OF DEATH MAY 26, 1969 10:55 P.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL | | | A. STATE MARYLAND B. COUNTY Baltimore | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN BALTIMORE | | |
| | | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER 3511 GARDENVIEW ROAD | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH 9-5-1904 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days |
| | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED | | 10B. KIND OF BUSINESS OR INDUSTRY C?P.A. | 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME ABRAHAM BOMSTEIN | | | 14. MOTHER'S MAIDEN NAME SARAH LOKOM | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 212-05-7883 | 17. INFORMANT ADDRESS MRS. DOROTHY BOMSTEIN, 3511 GARDENVIEW ROAD | | |
| 18. 410.9 I CAUSE OF DEATH acute myocardial infarction | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/26 1966 to 5/26 1969 that (I) (we) last saw the deceased alive on 5/26 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Milton B. Kirsh | | | | 23B. DATE SIGNED 5/27/69 | |
| 23C. PHYSICIAN'S NAME (Type) MILTON B. KIRSH | | | | 23D. ADDRESS 4000 W. NORTHERN PKWY. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 5-28-69 | | 24C. NAME OF CEMETERY or CREMATORY BETH TFILOH | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 3 1969 | | 25B. NAME OF REGISTRAR John E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| P-254 | | 69 5566 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | 69 5566 | |
|---|--|------------------------|--|---|--|---|--|--|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| YETTA POSNER | | | | MAY 26, 1969 | | | | 2:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | | | B. COUNTY | |
| 2 SINAI HOSP. OF BALTIMORE | | | | MARYLAND | | | | BALTIMORE | |
| | | | | C. CITY OR TOWN | | | | D. INSIDE CITY LIMITS? | |
| | | | | BALTIMORE | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | | 6940 BROOKMILL ROAD | |
| | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| FEMALE | | WHITE | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 7/10/1901 | | 69 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | AT HOME | | | | RUSSIA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| BERNARD KADISH | | | | ROSALIE | | | | U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | | | MR. BERNARD POSNER, 3313 TERRAPIN ROAD #21208 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | about one month | |
| ANTECEDENT CAUSES | | | | (B) MYELOID METAPLASIA DUE TO, OR AS A CONSEQUENCE OF: | | | | ? yes. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | | | |
| II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | ? yes. | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| O | | | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | White <input type="checkbox"/> At Work <input type="checkbox"/> Not White <input type="checkbox"/> At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 26, 1969 to May 26, 1969 that (I) (we) last saw the deceased alive on May 26, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Wilhelmina P. Cafucan M.D. | | | | | | | | 5-26-69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | | | |
| WILHELMINA P. CAFUCAN, M.D. | | | | | | SINAI HOSP. OF BALTIMORE, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| BURIAL | | 5-28-69 | | BNAI ISRAEL | | BALTIMORE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JUN 3 1969 | | Julius E. Talbot M.D. | | SOL LEVINSON & BROS. | | 6010 REISTERSTOWN ROAD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5567 | |
|--|-------------------------|---|--|---|--|
| BIRTH NO. R-251 | | | | 69 5567 | |
| 1. NAME OF DECEASED
(Type or Print) BENJAMIN - ROSENBERG | | | 2. DATE AND HOUR OF DEATH
5-25-69 5⁴⁰ PM M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
BELVEDERE NURSING HOME | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY MD
C. CITY OR TOWN BALTO.
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 14 W Cold Spring Lane, APT. 209 | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-25-97 | 9. AGE (In years last birthday)
71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MANAGER | | 10B. KIND OF BUSINESS OR INDUSTRY
RETAIL SHOES | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | |
| 13. FATHER'S NAME
MAX ROSENBERG | | | 14. MOTHER'S MAIDEN NAME
BESSIE HOFFMAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MRS. MOLLYE ROSENBERG | |
| 18. 412.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
= 1 - Acute C. V. A.
= 2 - Reperfusion and lab. myocardial infarction - (Premonitory tachycardia)
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from March 22, 1969 to 5-25-1969 , that (I) (we) last saw the deceased alive on 5-25-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Bernard J. Cohen, M.D. | | | 23B. DATE SIGNED
5-25-69 | | 23C. PHYSICIAN'S NAME (Type)
BERNARD J. COHEN, M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | 24B. DATE
5-27-69 | | 24C. NAME OF CEMETERY OR CREMATORY
HEBREW FRIENDSHIP |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | 25B. NAME OF REGISTRAR
J. E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD |

Handwritten notes at the top left, including a date and some illegible text.

Handwritten notes in the middle left, including a date and some illegible text.

Handwritten notes at the bottom left, including a date and some illegible text.

Handwritten notes at the top right, including a date and some illegible text.

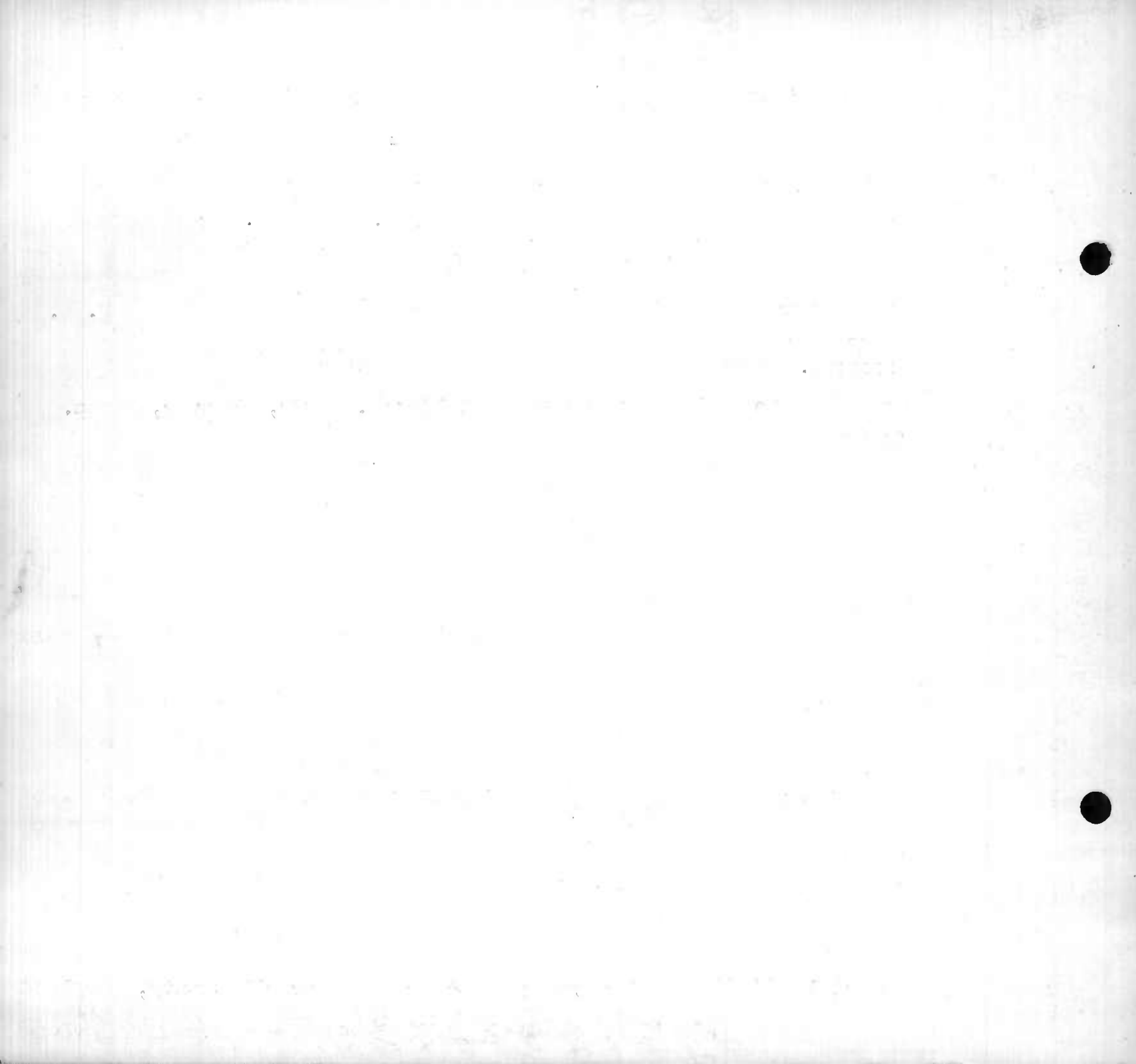
Handwritten notes in the middle right, including a date and some illegible text.

Handwritten notes at the bottom right, including a date and some illegible text.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5568 |
|---|------------------|---|-----------------------------|---|
| BIRTH NO. | | 69 5568 | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| Edna Baker | | 5/30/69 10:15 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Harbor View Nursing Home | | A. STATE
Maryland | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
Baltimore #21218 | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 90 | | E. STREET AND NUMBER
2930 N. Calvert St. | | |
| 5. SEX
F | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/18/84 | 9. AGE (In years last birthday)
84 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housekeeper | | 10B. KIND OF BUSINESS OR INDUSTRY
at home | | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. | | 13. FATHER'S NAME
Philip | | |
| 14. MOTHER'S MAIDEN NAME
Julia Smith | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no no | | |
| 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
William E. Baker, Hanover, Penna. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
486 X I
Pneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Arteriosclerotic Cardiovascular Disease, etc. | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (this hospital) attended the deceased from 5/123 1969 to 5/30 1969, that (we) lost saw the deceased alive on 5/30 1969 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
H.C. Alevizatos, M.D. | | 23B. DATE SIGNED
5/30/69 | | 23C. PHYSICIAN'S NAME (Type)
H.C. ALEVIZATOS, M.D. |
| 23D. ADDRESS
1209 St. Paul St. Baltimore 21212 | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | |
| 24B. DATE
6/2/69 | | 24C. NAME OF CEMETERY or CREMATORY
Pipe Creek Cemetery | | 24D. LOCATION (City, town, or county) (State)
Carroll County, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
NEW WINDSOR |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5569 |
|---|-----------------------------|---|------------------------------------|---|
| BIRTH NO. 69 5569 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Ball, Emily L.</i> | | 2. DATE AND HOUR OF DEATH
<i>5/28/69 3:15p. M.</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>Bon Secours Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>MARYLAND.</i>
B. COUNTY <i>25-31</i> | | |
| | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
<i>5151 Frederick Ave. - 21229</i> | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>7-27-86</i> | 9. AGE (In years last birthday)
<i>82</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Ret. Checker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Belvedere Hotel</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | | 13. FATHER'S NAME
<i>(Unknown) Fathe</i> | | |
| 14. MOTHER'S MAIDEN NAME
<i>Margaret Bardoff</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | |
| 16. SOCIAL SECURITY NO.
<i>215-031172</i> | | 17. INFORMANT
<i>C. Edward Ball 5151 Frederick Ave. 21229</i> | | |
| 18. CAUSE OF DEATH
I. <i>250.0 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

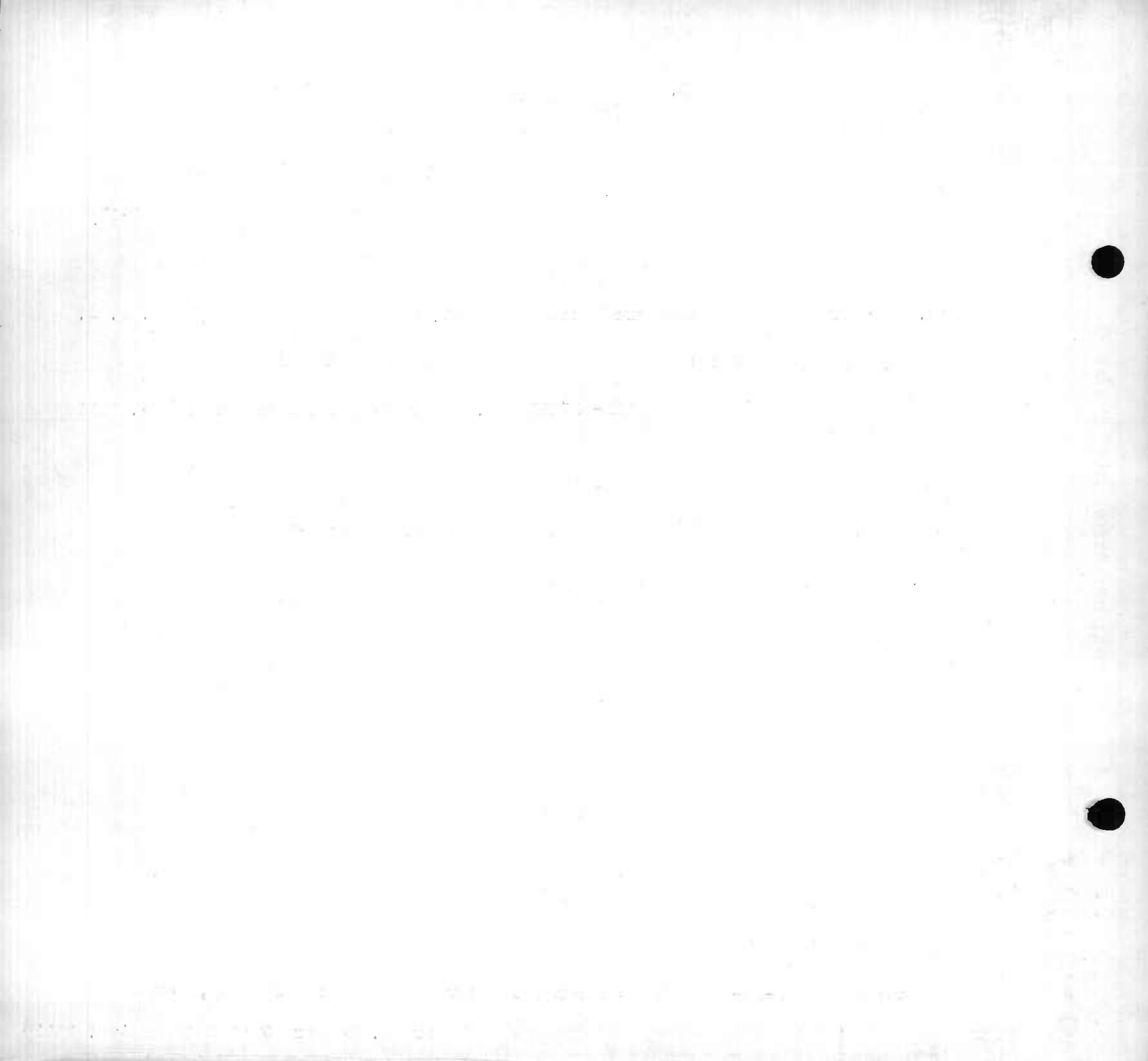
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

A. IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>coma</i>

B. <i>Uremia, Septicemia</i>
DUE TO, OR AS A CONSEQUENCE OF:

C. <i>Diabetes mellitus (K-W)</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>6 days.</i>

<i>?</i>
<i>?</i> |
| MEDICAL CERTIFICATION | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>—</i> | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<i>—</i> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
<i>—</i> |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
<i>—</i> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<i>—</i> |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5/28/69</i> to <i>5/28/69</i> that (I) (we) last saw the deceased alive on <i>5/28/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<i>Vallop</i> | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>5/28/69</i> |
| 23C. PHYSICIAN'S NAME (Type)
<i>VALLOP</i> | | 23D. ADDRESS
<i>Bon Secours Hosp, Balto, Md. 21223</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | 24B. DATE
<i>5-31-69</i> | 24C. NAME OF CEMETERY OR CREMATORY
<i>New Cathedral Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore City, Maryland</i> |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 3 1969</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Howard H. Hubbard</i> |
| | | | | ADDRESS
<i>4107 Wilkens Ave. 21229</i> |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5570 CERTIFICATE OF DEATH

REG. NO. 69 5570

| | | | | | |
|--|---------|--|------------------|---|----------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | HURLEY, KATHRYN ANGELA | | MAY 27, 1969 11:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| 40 ST AGNES HOSPITAL | | | | MARYLAND | |
| | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | | | BALTIMORE YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | |
| | | | | 3109 N CHARLES STREET 21218 | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Yr. Months Days |
| FEMALE | WHITE | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 03 10 02 | 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | MARYLAND | |
| 13. FATHER'S NAME N. | | 14. MOTHER'S MAIDEN NAME A. | | 12. CITIZEN OF WHAT COUNTRY? | |
| JOSEPH SHEW | | KATHRYN HOLMES | | U S A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 220 12 8582 | | Alice Fassel 3604 Ednor Rd. Balto. 21218 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Septicemia - Ruptured Blurry | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Rheumatic Heart disease - | | | |
| | | (B) Bacterial Endocarditis | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (IX) (this hospital) attended the deceased from MAY 26 1969 to MAY 27 1969 that (X) (we) last saw the deceased alive on MAY 27 1969 and that (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| RODOLFO REVILLA | | | | 05 29 69 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | ST AGNES HOSP. BALTO MD 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 5-31-69 | | Baltimore National Cemetery | |
| | | | | Baltimore City, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUN 3 1969 | | Robert E. Taylor, M.D. | | Howard H. Hubbard 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---------|--|------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 69 5571 | |
| 69 5571 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>Mildred H. Tilstra</u> | | 5-27-69 1 ¹⁰ A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| 37 Mercy Hospital | | Maryland Balto. Co. 53-00 | |
| | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | Baltimore YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | |
| | | 3106 Dubois Ave | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH |
| F | W | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 5-10-3 |
| | | 9. AGE (In years last birthday) 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| Seamstress | | Pennsylvania | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| Tailoring | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Abel M. Hess | | Elizabeth Hanna | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| No | | ? | |
| 17. INFORMANT | | ADDRESS | |
| Preston A. Pairo | | 800 Court Square Bldg. 21202 | |
| 18. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES | | MYOCARDIAL INFARCTION | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ARTEROSCLEROTIC CARDIOVASCULAR DISEASE | |
| | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CELIAC ARTERY OCCLUSION | |
| 19A. DATE OF OPERATION | | 20A. AUTOPSY? (Yes or No) | |
| 22 MAY 69 | | YES | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| EXPLORATORY LAPAROTOMY | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Involuntarily medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 22. I certify that (1) (this hospital) attended the deceased from | | 21F. HOW DID INJURY OCCUR? | |
| that (1) (we) last saw the deceased alive on | | | |
| and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | |
| Salvatore R. Donohue MD | | 27 May 69 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| SALVATORE R. DONOHUE MD | | Mercy Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| Burial | | 5-31-1969 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Dulaney Valley Memorial | | Cockeysville, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| JUN 3 1969 | | John E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |
| Wm. Cook-Brooks | | Towson 1050 York Rd. 21204 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|------------------------------------|---|---|
| 69 5572 | | CERTIFICATE OF DEATH | | REG. NO. 69 5572 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>LETT, Thelma Mae</i> | | 2. DATE AND HOUR OF DEATH
<i>5-28-69 5:25 PM</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i> | | M. <i>23-02</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>South Baltimore General Hosp</i>
<i>43</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<i>Baltimore</i> | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<i>1606 OLIVE ST</i> | |
| 5. SEX
<i>FEMALE</i> | 6. RACE
<i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>5-22-22</i> | 9. AGE (In years last birthday)
<i>47</i> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>W. Virginia</i> | |
| 13. FATHER'S NAME
<i>John Mc Donough</i> | | 14. MOTHER'S MAIDEN NAME
<i>Gertrude Nelson</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>no</i> | | 16. SOCIAL SECURITY NO.
<i>214-18-1555</i> | | 17. INFORMANT
<i>Kenneth Lett. same as #4</i> | |
| 18. <i>180X 41 230.9</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<i>Probable MI unknown a pul embolism</i>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <i>Diabetes, ischaemic heart disease</i>
DUE TO, OR AS A CONSEQUENCE OF:
(C) <i>ex cervix</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5-10-1969</i> to <i>5-28-1969</i> that (I) (we) last saw the deceased alive on <i>5-27-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Khawla Abousy</i> | | 23B. DATE SIGNED
<i>5-28-69</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>KHAWLA ABOUSY</i> | |
| 23D. ADDRESS
<i>Saul Baltimore grand Hosp.</i> | | 23E. NAME OF CEMETERY OR CREMATORY
<i>Balto. Nat'l Cem.</i> | | 23F. LOCATION (City, town, or county) (State)
<i>Balto. Md.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>5-31-69</i> | | 24C. NAME OF FUNERAL DIRECTOR
<i>Robert E. Talley, Jr.</i> | |
| 24D. DATE REC'D BY HEALTH DEPT.
<i>JUN 3 1969</i> | | 24E. NAME OF REGISTRAR
<i>Robert E. Talley, Jr.</i> | | 24F. FUNERAL DIRECTOR ADDRESS
<i>130 E. Fort Ave. 21230</i> | |



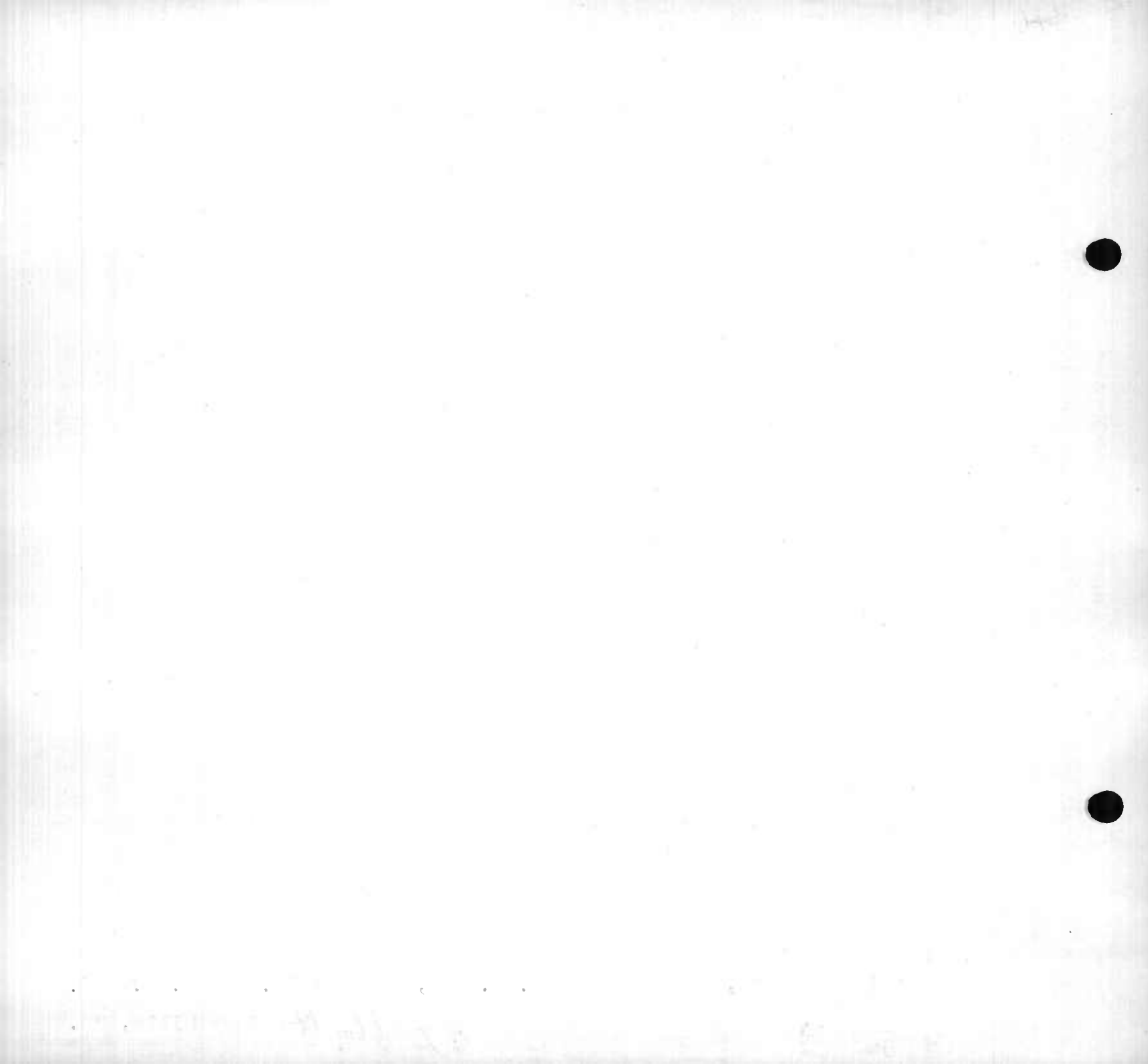
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5573 | |
|---|------------|--|------------------------------|--|---|
| BIRTH NO. | | 69 5573 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Mrs. Anna M. Sibley | | 2. DATE AND HOUR OF DEATH
5.26.69 4-22P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
48 Maryland General Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore Co.
C. CITY OR TOWN Lutherville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER Box. 355 Greenspring Ave. | | | |
| 5. SEX F | 6. RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11,24,88 | 9. AGE (In years last birthday)
80 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Joseph Wilson | | 14. MOTHER'S MAIDEN NAME
Phillips | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-12-4485 | | 17. INFORMANT
Robert L. Sibley
Husband | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

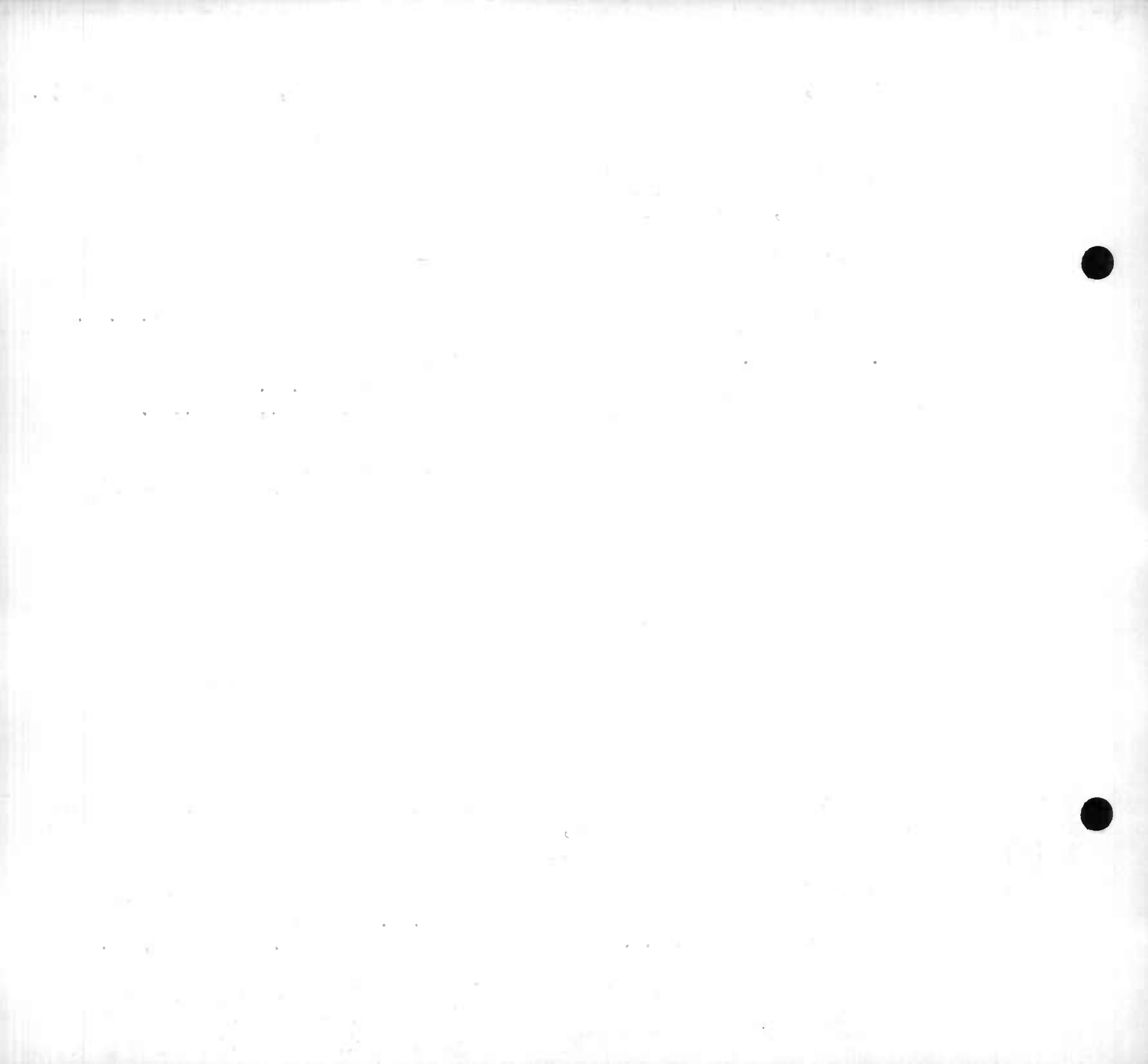
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 18. CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
cardiogenic shock
(B) Ac. Myocardial infarction
(C) Diabetes mellitus, Arterio- | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 hours
1 day
1 year | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):
sclerotic cardiovascular disease | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4.26.69 1969 to 4.26.1969, that (I) (we) last saw the deceased alive on 5.26.1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Mohammed Sidiq | | 23B. DATE SIGNED
5.26.69 | | 23C. PHYSICIAN'S NAME (Type)
MOHAMMAD SIDIQ M.B.B.S. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
May 29, 1969 | | 24C. NAME OF CEMETERY or CREMATORY
Saters Bap. Ch. Cem. | |
| 24D. LOCATION
Falls Rd., Balto. Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
J. E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
H. J. Zehner | | 25D. ADDRESS
Owings Mills, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

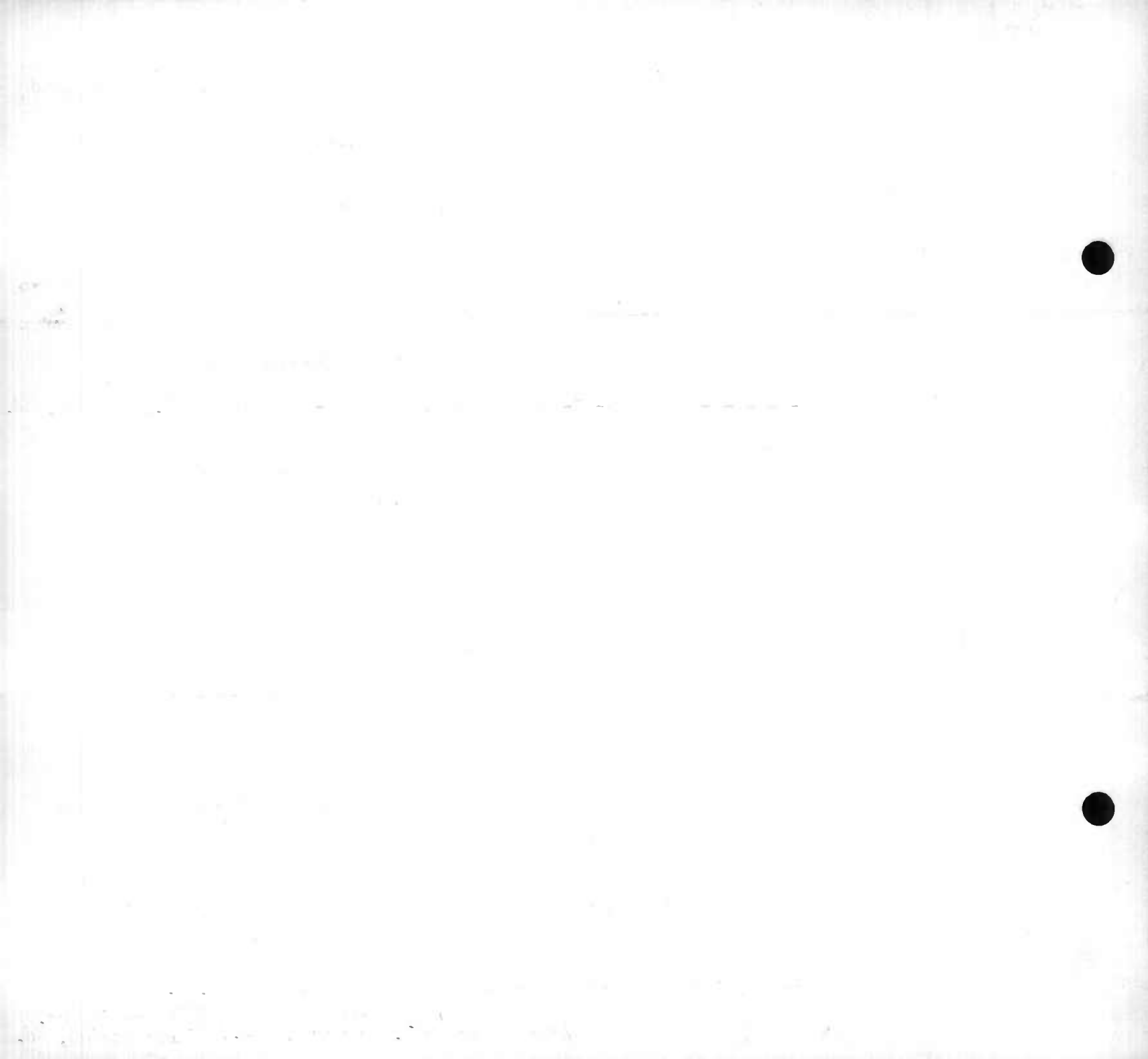
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|--|--|--|--|--|
| 69 5574 | | 69 5574 | | 69 5574 | |
| 1. NAME OF DECEASED
(Type or Print) TRICKA, FRANK JOSEPH | | | 2. DATE AND HOUR OF DEATH
May 25, 1969 1:00 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX Male 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 10-16-93 9. AGE (in years last birthday) 73 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dry Cleaner Manager | | | 11. BIRTHPLACE (State or foreign country) Maryland | | |
| 10B. KIND OF BUSINESS OR INDUSTRY Unknown | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME Frank J. Tricka, Sr. | | | 14. MOTHER'S MAIDEN NAME Anna Harrant | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 8-11-17 to 12-8-18 | | | 16. SOCIAL SECURITY NO. 212-18-1218 | | |
| 17. INFORMANT Records V. A. Hospital ADDRESS 3900 Loch Raven Blvd., Balto., Md. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Carcinoma of the lung with metastases | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
less than 1 year | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that XII (this hospital) attended the deceased from April 8, 1969 to May 25, 1969 that XII (we) last saw the deceased alive on May 25, 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. XII (We) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE Edward Rusche | | | | 23B. DATE SIGNED 5/26/69 | |
| 23C. PHYSICIAN'S NAME (Type) EDWARD RUSCHE, M.D. | | | | 23D. ADDRESS V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5-27-69 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National | |
| 24D. LOCATION (City, town, or county) Baltimore Md. | | 24E. STATE Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 3 1969 | | 25B. NAME OF REGISTRAR Robert E. Taber, M.D. | | 25C. FUNERAL DIRECTOR Wm. S. Trickett & Sons | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------------|--|---|---|--|---|--|---|--|
| 69 5575 CERTIFICATE OF DEATH | | | | | REG. NO. | | 69 5575 | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Trageser John A.</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>5/18/69</u> # <u>11:10 AM</u> <small>M.</small> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>Carroll</u> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>University Hosp</u> | | | | | C. CITY OR TOWN
<u>MT Airy</u> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER
<u>Rt # 2 Flagmarsh Rd</u> | | | | | | | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<u>7/25/04</u> | 9. AGE (in years last birthday)
<u>64</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Farming</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Wash. D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 13. FATHER'S NAME
<u>John Trageser</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Henrietta ALB RICHTER</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>214-03-2909</u> | | 17. INFORMANT (Son) <u>Charles Trageser-2700 Newton St., Wheaton, Md.</u> | | | | |
| 18. CAUSE OF DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Pulmonary embolus</u>
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>and/or pulmonary infarction</u> | | | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Pneumonia, Hypothyroidism</u> | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> 19 <u>69</u> to <u>5/18</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>5/18</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>M. B. Troner M.D.</u> | | | | | 23B. DATE SIGNED
<u>5/18/69</u> | | | 23C. PHYSICIAN'S NAME (Type)
<u>M. B. TRONER</u> | |
| 23D. ADDRESS
<u>Univ. Hosp.</u> | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>May 21, 1969</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Glenwood Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Washington, D. C.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Wagner & Smith, Inc., 8434 Georgia Ave., Silver Spring, Md.</u> | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5576 CERTIFICATE OF DEATH

REG. NO. 69 5576

| | | | | | |
|---|-------------------------|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Heatterick, Henry J.</i> | | 2. DATE AND HOUR OF DEATH
<i>6/2/69 8:37 A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>MD</i> B. COUNTY <i>21-02</i> | | 5. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>South Baltimore General Hospital</i> | | E. STREET AND NUMBER
<i>1148 Washington Blvd (21230)</i> | | F. DATE OF BIRTH
<i>9/12/196</i> | |
| 6. SEX
<i>M</i> | 7. RACE
<i>white</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. AGE (in years last birthday)
<i>72</i> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Legationary Dept</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Balti. City</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Balti. Ind</i> | |
| 13. FATHER'S NAME
<i>Conrad Heatterick</i> | | 14. MOTHER'S MAIDEN NAME
<i>Rosie Annie Pfarr</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | 16. SOCIAL SECURITY NO.
<i>220-092940</i> | | 17. INFORMANT
<i>chart. Hosp.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>569.9 I Bilateral pneumonia</i> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>GI bleeding</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 weeks</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>4 weeks</i> | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<i>Uremia, Dehydration</i> | | <i>6 months</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5/31</i> 19 <i>69</i> to <i>6/2</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>6/2</i> 19 <i>69</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Sang Y. Rhim</i> | | 23B. DATE SIGNED
<i>6/2/69</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>SANG Yoon Rhim</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6/5/69</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Int. Olivet Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Balti. Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 3 1969</i> | | 25B. NAME OF REGISTRAR
<i>Charles E. Fisher, R.D.</i> | |
| 25C. FUNERAL DIRECTOR
<i>John B. Gwansdar Inc.</i> | | 25D. ADDRESS
<i>2801 St.</i> | | 25E. ADDRESS
<i>2801 St.</i> | |

1912

Received of Mr. J. H. Smith
the sum of \$100.00
for the purchase of land
in the town of Smith
County, Iowa.

Witness my hand and seal
this 1st day of January
1912.

John H. Smith
Notary Public
for the State of Iowa

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 5577

| | | | | | |
|--|-----------------------------|---|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print)
James J. Primus Jr. | | 2. DATE AND HOUR OF DEATH
May 31, 1969 8 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 27-14 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
4410 Sedgwick Road | | C. CITY OR TOWN
Baltimore | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
4410 Sedgwick Road | |
| 5. SEX
Male | 6. RACE
Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 23, 1905 | 9. AGE (In years last birthday)
64 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Food Business | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
James J. Primus Sr. | | 14. MOTHER'S MAIDEN NAME
Elizabeth Kostelak | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
318-03-2522 | | 17. INFORMANT
Miss Penelope L. Primus | |
| | | | | ADDRESS
Same | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction Sudden | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Coronary Insufficiency Link. | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Polycaethenia Vera | | | | 6 yrs. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the undersigned) attended the deceased from Feb 1962 to May 31 1969 , that (I) last saw the deceased alive on May 30 1969 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the undersigned) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph F. LiPira M.D. | | 23B. DATE SIGNED
June 2, 1969 | | 23C. PHYSICIAN'S NAME (Type)
Joseph F. LiPira M.D. | |
| 23D. ADDRESS
8400 Loch Raven Blvd. Baltimore Maryland | | 23E. FURNAL DIRECTOR
Leonard J. Buck Inc. | | 23F. ADDRESS
5305 Harford Road 21211 | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
Entombment | | 24B. DATE
6/2/69 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Park Mausoleum | |
| 24D. LOCATION
Baltimore Maryland | | 24E. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 24F. NAME OF REGISTRAR
John E. Taylor, M.D. | |

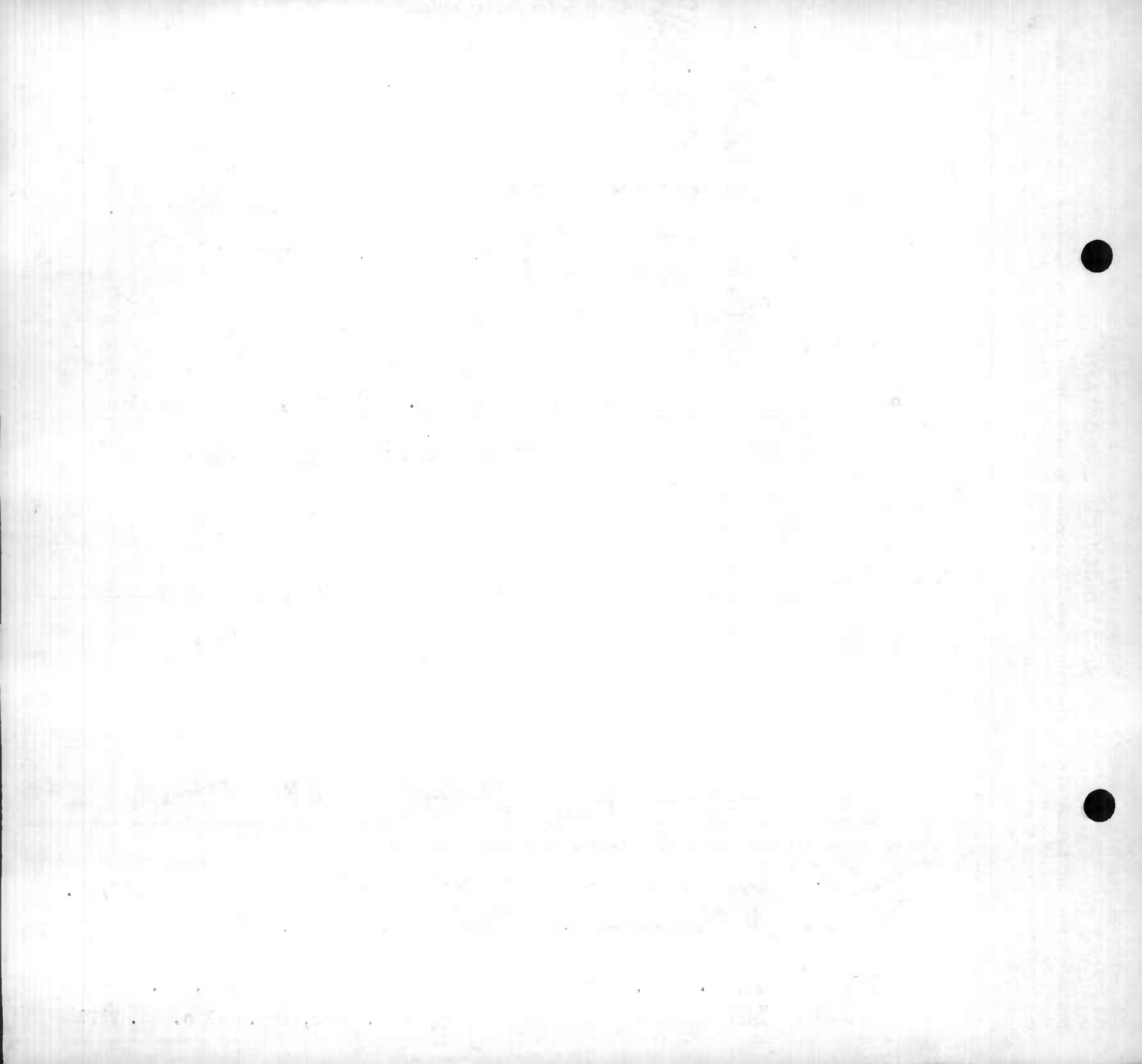
Robertson's
Company
Superior

May 20 1890
J. F. Robertson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 69 5578 |
|---|---------|--|---|--|---|
| BIRTH NO. | | 69 5578 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Bertha L. Davis | | 5/30/69 4:15 am | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| DOMELCHER NURSING Home | | | BALTO MD. | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 2630 East Hoffman St. | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days |
| F | C | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | SEPT 17, 1876 | 93 92 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | MD. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| CONRAD BECK | | SOFTA BOEHRINGER | | US. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 212-07-5819 | | Mr. David Ross, 706 Benston Place | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | Arteriosclerotic Cardio-vascular disease | | Several years | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from August 1964 to May 1969, that (I) last saw the deceased alive on May 29 1969 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Loy M. Zimmerman M.D. | | 5/30/69. | | | |
| 25C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Loy M. Zimmerman M.D. | | 3202 Harford Rd, Baltimore, Md | | | |
| 24A. BURIAL CREMATION | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 6/2/69. | | Mt. Olivet Cemetery | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUN 3 1969 | | E. J. Ruck, M.D. | | Leonard J. Ruck, Inc. Balto. Md. 21214 | |

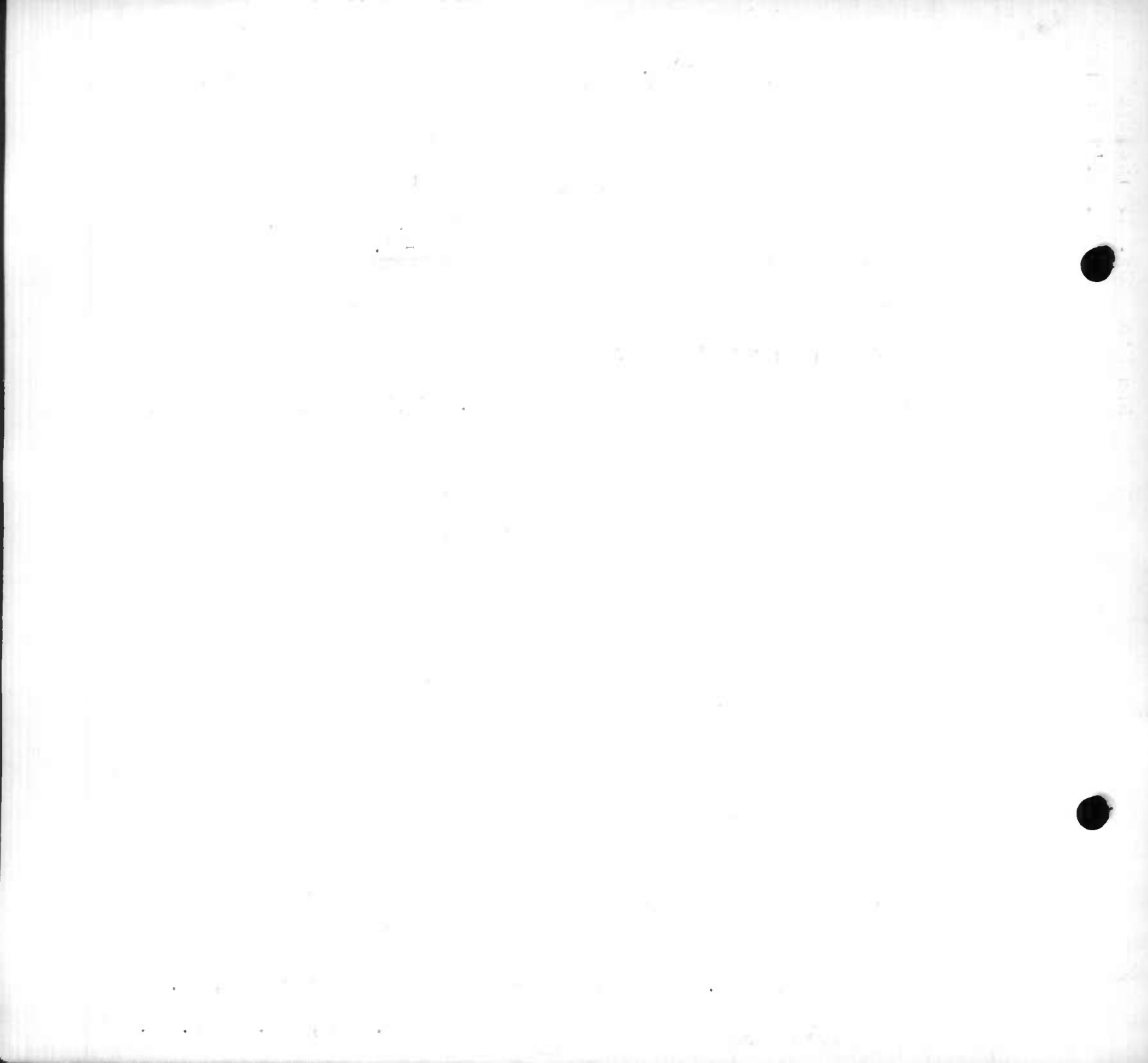


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5578 CERTIFICATE OF DEATH

REG. NO. 69 5578

| | | | | | |
|--|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | (Teresa) O.
THERESA HEILKER | | 5/28/69 8:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE
MARYLAND | |
| THE JOHNS HOPKINS HOSPITAL
33 | | | | B. COUNTY
10-01 | |
| 5. SEX
FEMALE | | 6. RACE
WHITE | | C. CITY OR TOWN
BALTIMORE | |
| | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | E. STREET AND NUMBER | |
| Housewife | | | | 934 E. EAGER ST. | |
| 8. DATE OF BIRTH
2-23-86 | | 9. AGE (In years last birthday)
82 | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Walter Phillips | | | |
| | | 14. MOTHER'S MAIDEN NAME
ANNA Walter | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. Phillip Heilker | |
| | | | | ADDRESS
(Same) | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
412.41
Prob MI on Pulmery | | | | | |
| (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| ASCVD & CHF | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 5/28/69 to 5/28/69 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
MARC Lippman MD | | | | 23B. DATE SIGNED
5/28/69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| MARC Lippman MD | | | | JHH | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 5/31/69 | | Moreland Memorial Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 3 1969 | | E. J. Gable, M.D. | | Leonard J. Ruck, Inc. Balto. Md. 21214 | |
| 25D. LOCATION (City, town, or county) (State) | | 25E. ADDRESS | | | |
| Baltimore, Md. | | 21214 | | | |

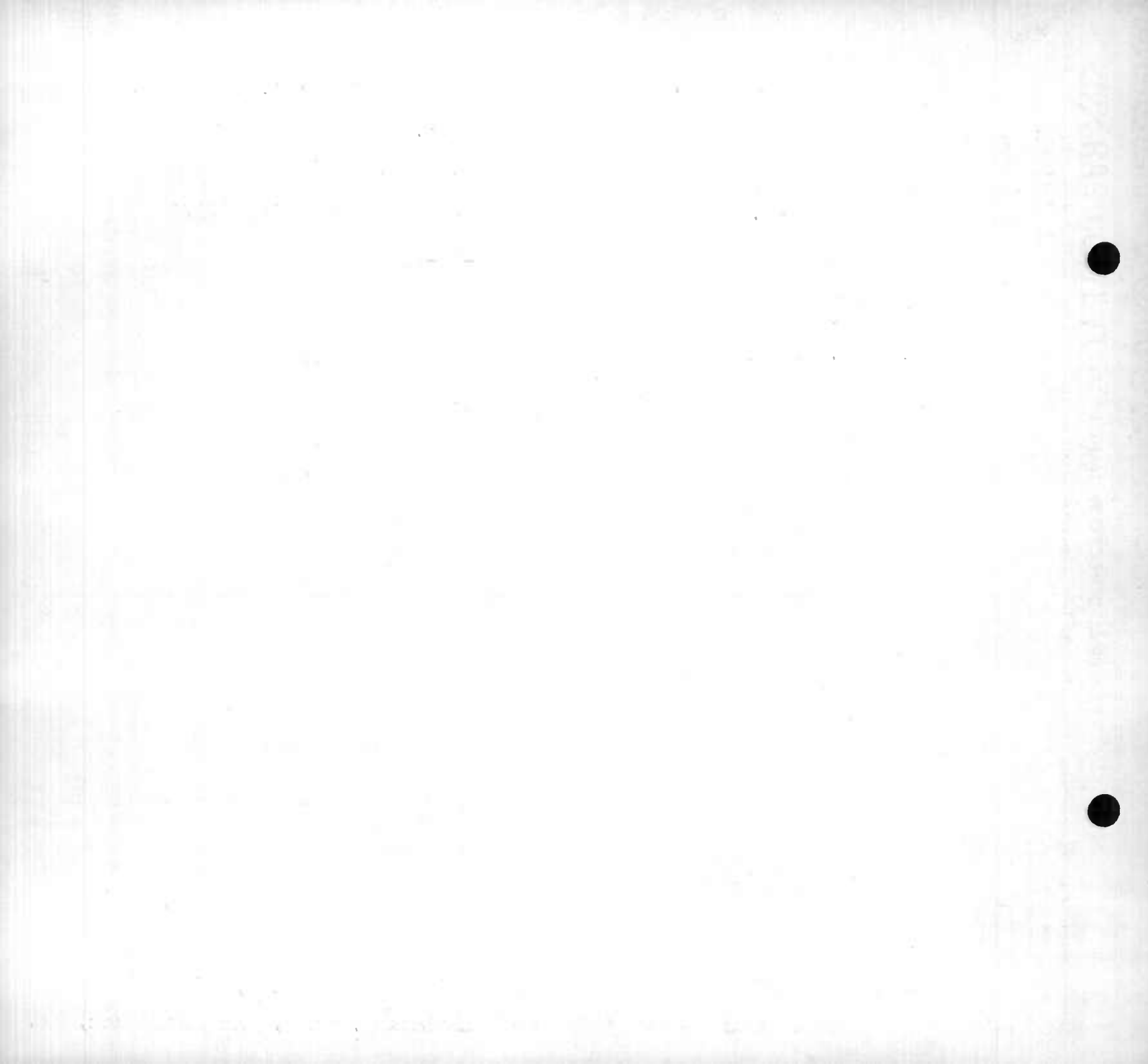


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 5580

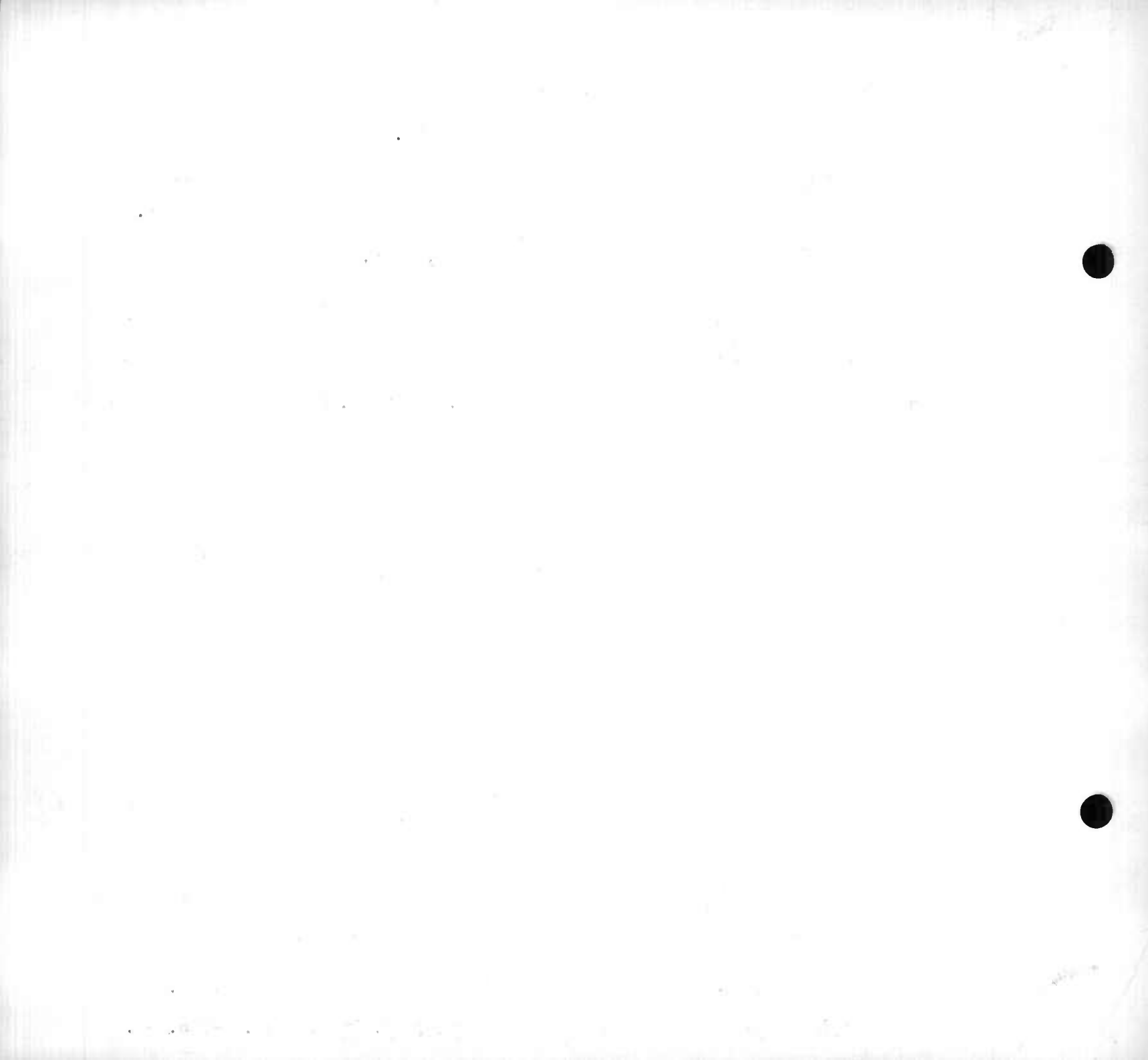
| | | | | | |
|--|------------------|---|--|---|---------------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Bertha B. Daniel | | May 30, 1969 7 am | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
House In the Pines
Belvedere Ave. | | | | A. STATE
Md. | |
| | | | | B. COUNTY | |
| | | | | C. CITY OR TOWN
Baltimore | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
1205 Glenwood Ave 21212 | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7-23-1888 | 9. AGE (In years last birthday)
80 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 13. FATHER'S NAME
James K. Wright | | | | 14. MOTHER'S MAIDEN NAME
Mollie Boswell | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
226036189a | | 17. INFORMANT
Eugene Daniel | |
| | | | | ADDRESS
same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
562.14 1150 X
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE
Due to, or as a consequence of:
acute diverticulitis | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Corrosion of esophagus. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months | |
| 19A. DATE OF OPERATION
Nov. 1968 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Diverticulitis with abscess. | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 29 1962 to May 22 1969, that (I) (we) last saw the deceased alive on May 22 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Samuel Whitehouse M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
SAMUEL WHITEHOUSE | | | | 23D. ADDRESS
3901 N. Charles St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/2/69 | | 24C. NAME OF CEMETERY or CREMATORY
Spring Hill Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Lynchburg, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
John E. Talley, M.D. | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5581 4 | |
|--|------------------|---|-----------------------------------|---|---|
| BIRTH NO. 49.9774 69 5581 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Baby Boy B Gibson | | 2. DATE AND HOUR OF DEATH
5/30/69 7:45 A.M. | | | |
| 3. PLACE IN BALTIMORE/MARYLAND WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. B. COUNTY 27-48 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
37 Mercy Hosp, Inc | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | C. CITY OR TOWN
Baltimore | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
5693 Purdue Ave. | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 29, 1969. | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Joseph Gibson | | 14. MOTHER'S MAIDEN NAME
Hildegard Andorfer | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mr. Joseph W. Gibson
ADDRESS (Same) | |
| 18. 776.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF:
(B) Massive atelectasis and aspiration
DUE TO, OR AS A CONSEQUENCE OF:
(C) Prematurity | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
17 hrs. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 28 19 69 to May 30 19 69
that (I) (we) lost saw the deceased alive on May 30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
S.K. Shin | | 23B. PHYSICIAN'S NAME (Type)
S.K. SHIN | | 23C. DATE SIGNED
5/30/69 | |
| 23D. ADDRESS
Mercy Hospital | | 23E. DEGREE
DEGREE | | 23F. ADDRESS
Mercy Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/3/69. | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | 24E. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 24F. NAME OF REGISTRAR
Robert E. Jones, M.D. | |
| 24G. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 24H. NAME OF REGISTRAR
Robert E. Jones, M.D. | | 24I. FUNERAL DIRECTOR
Leonard J. Buck, Inc. Balto. Md. | |



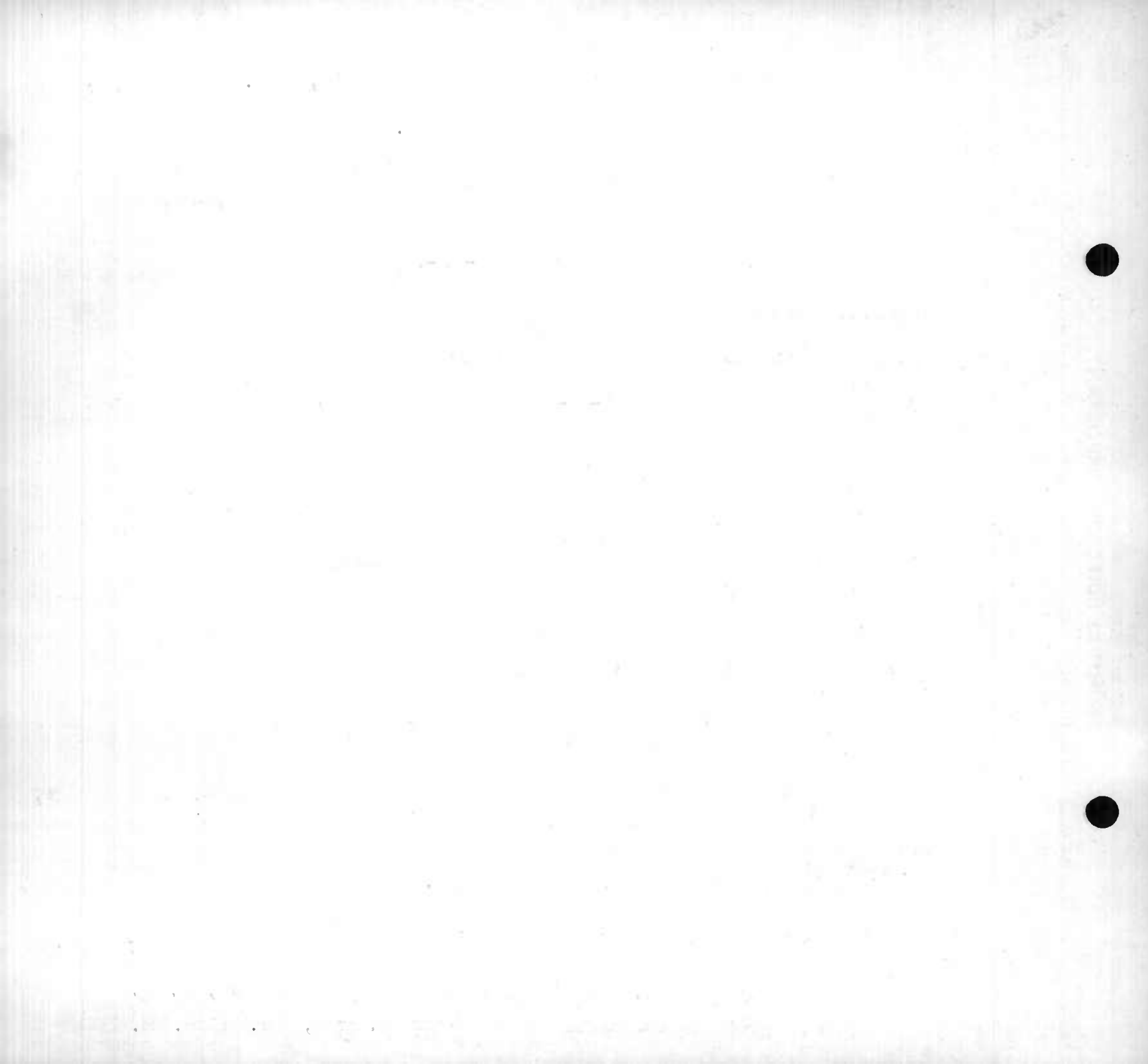
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5582 |
|--|--|--|--|---|
| BIRTH NO. 69 5582 | | | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) Joseph Cosimano | | 2. DATE AND HOUR OF DEATH
May 28, 1969. 10:55 p.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
5411 Tramore Road | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 27-06 | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 2-21-1873 | | 9. AGE (In years (last birthday) 96 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Dealer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Italy |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Joseph Cosimano | | |
| 14. MOTHER'S MAIDEN NAME not known | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 213-48-8289 | | 17. INFORMANT Mrs Camille Cusimano | | |
| 18. ADDRESS same | | 19. CAUSE OF DEATH | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerosis
cardiovascular disease
(B) DUE TO, OR AS A CONSEQUENCE OF:
generalized arterio-sclerosis
(C) _____ | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 years | | 5 years | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 1964 to May 28 1969, that (I) (we) last saw the deceased alive on May 28 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Ramon V. Goco M.D. | | 23B. DATE SIGNED May 30, 1969 | | 23C. PHYSICIAN'S NAME (Type) Ramon V. Goco M.D. |
| 23D. ADDRESS 5500 Bawly Lane, Baltimore Md. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 6/2/69 | | 24C. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 24D. LOCATION (City, town, or county) (State) Washington, D. C. |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 3 1969 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS Leonard P. Buck, Inc. Balto. Md. 21214 |



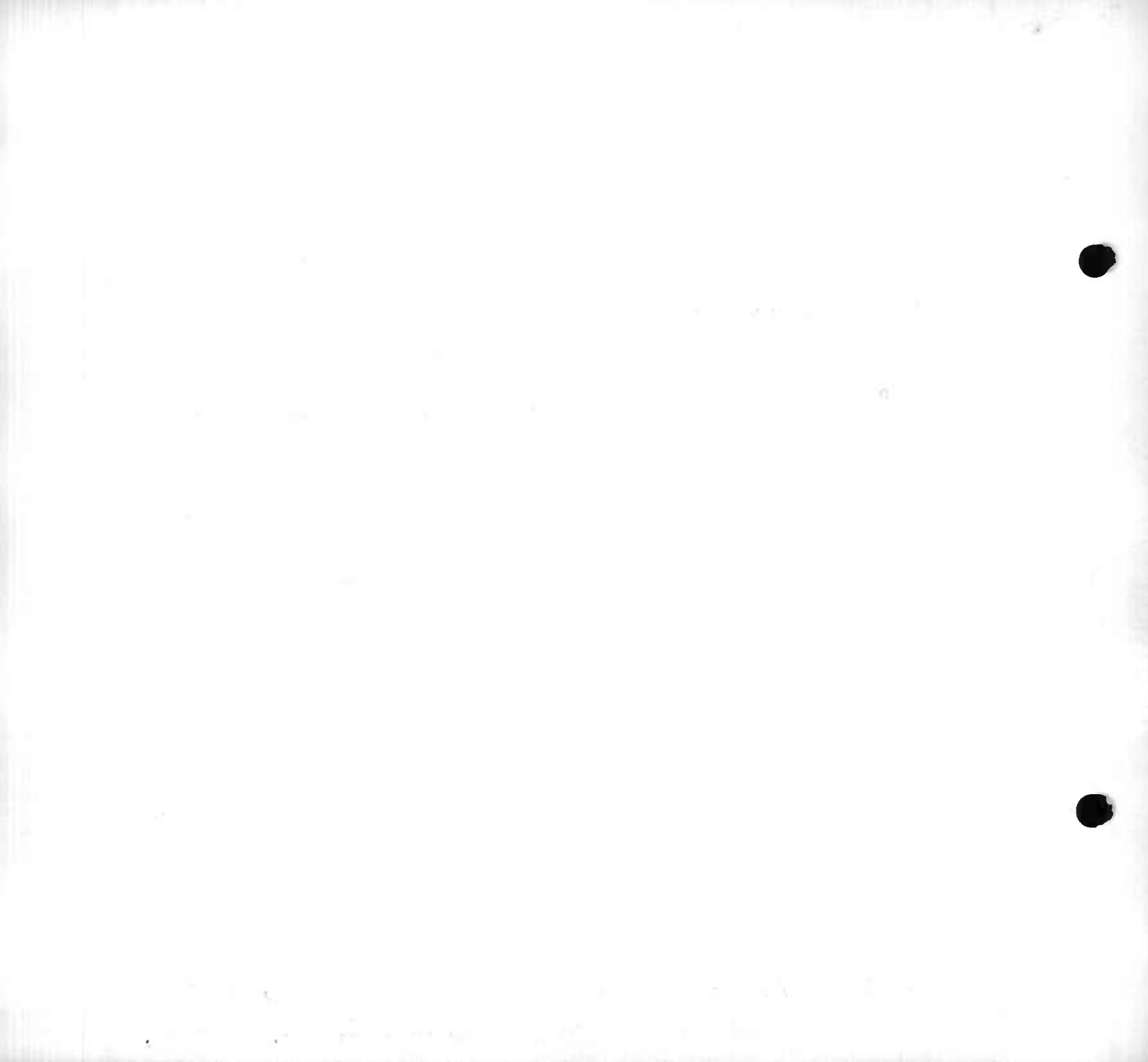
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5583 | |
|---|---------------------|---|---|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) HELEN M. RUTH | | 2. DATE AND HOUR OF DEATH
5-30-69 7:00 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE Md. B. COUNTY 4-01 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
NORTH CHARLES GENERAL HOSPITAL | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| ADDRESS OR LOCATION
BALTIMORE, Md. 21218 | | | E. STREET AND NUMBER
445 E. 25th BALTIMORE, Md. 21218 | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-12-96 | 9. AGE (In years last birthday)
72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED BOOK KEEPER | | | 10B. KIND OF BUSINESS OR INDUSTRY
Civil Service | | 11. BIRTHPLACE (State or foreign country)
Md. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
EDWARD RUTH | | |
| 14. MOTHER'S MAIDEN NAME
ANNA HILSON Gibson | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | |
| 16. SOCIAL SECURITY NO.
219 012736A | | | 17. INFORMANT
MRS. RUTH BAUER (NIECE) | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)
CEREBRO-VASCULAR ACCIDENT 20 6 days | | | 19. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
TO CEREBRAL THROMBOSIS | | |
| 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
DIABETIS MELLITUS | | | 21. DUE TO, OR AS A CONSEQUENCE OF:
ARTERIOSCLEROSIS, GENERALIZED | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
ARTERIOSCLEROSIS, GENERALIZED | | | | | |
| 19A. DATE OF OPERATION
0 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
NO | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
5-30-69 7:00 A.M. | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-24-69 19 to MAY 30, 1969 , that (I) (we) last saw the deceased alive on 5-30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Aurora P. Cuevas, M.D. | | | | 23B. DATE SIGNED
5-30-69 | |
| 23C. PHYSICIAN'S NAME (Type)
AURORA P. CUEVAS M.D. | | | | 23D. ADDRESS
NORTH CHARLES GEN. HOSP. BALTIMORE 18, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/2/69. | | 24C. NAME of CEMETERY or CREMATORY
Oaklawn Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Talley, M.D. | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|------------------------------------|---|---|
| 69 5584 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5584 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>MR. WALTER W. FRANSIS</i> | | 2. DATE AND HOUR OF DEATH
<i>5-29-69 8:15 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>MD</i> 8. COUNTY | | 26-43 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>CHURCH HOME AND HOSPITAL</i> | | C. CITY OR TOWN
<i>BALTIMORE</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER
<i>4119 ERDMAN AVE</i> | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>5-27-81</i> | 9. AGE (In years last birthday)
<i>88</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired Conductor B&O RR</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>MD</i> | |
| 13. FATHER'S NAME
<i>RICHARD FRANSIS</i> | | 14. MOTHER'S MAIDEN NAME
<i>UNK NOT AVAILABLE</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NOT KNOWN</i> | | 16. SOCIAL SECURITY NO.
<i>705-07-4137</i> | | 17. INFORMANT
<i>Mr George W Gerlach</i> ADDRESS
<i>Same</i> | |
| 18. <i>1990 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>GIT bleeding</i>
<i>metastasis</i>
(B) <i>Generalized Carcinomatosis</i>
DUE TO, OR AS A CONSEQUENCE OF:
(C) <i>CA of pancreas & colon</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5-16-69</i> to <i>5-29-69</i> and that (I) (we) last saw the deceased alive on <i>5-29-69</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Mesbah Uddin DOWLA MD</i> | | 23B. DATE SIGNED
<i>5/29/69</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>MESBAH UD-DOWLA MD</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6/2/69</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Baltimore</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 3 1969</i> | | 25B. NAME OF REGISTRAR
<i>John E. [illegible] MD</i> | |
| 25C. FUNERAL DIRECTOR
<i>Leonard J. [illegible]</i> | | 25D. ADDRESS
<i>Baltimore, Maryland</i> | | | |



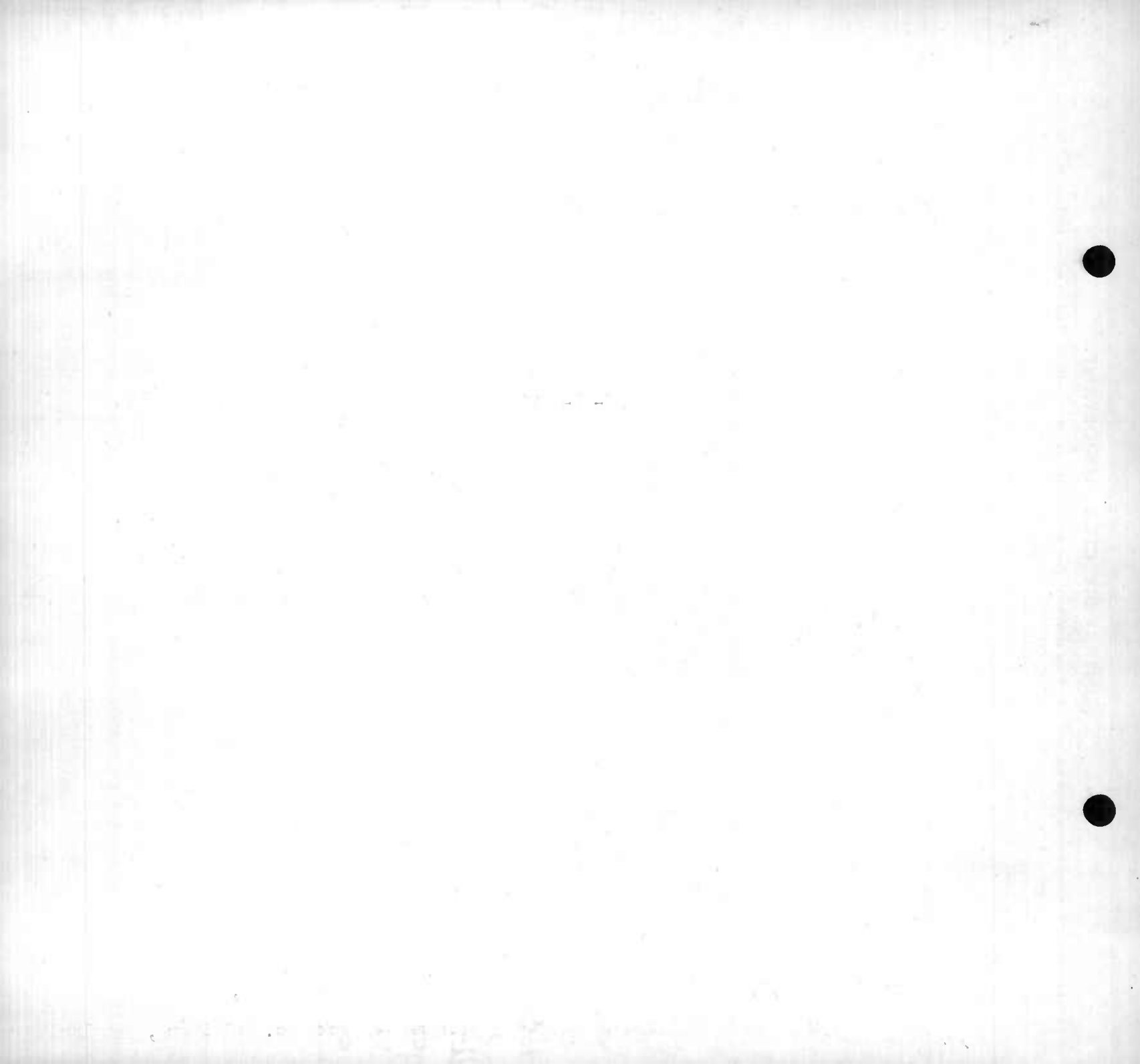
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 5585 BALTIMORE CITY HEALTH DEPARTMENT | | | | 69 5585 | |
|--|---------------------|--|--|--|---|
| CERTIFICATE OF DEATH | | | | REG. NO. | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Julia PALASKI</i> | | 2. DATE AND HOUR OF DEATH
<i>May 29, 1969 7:25 A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
<i>49 North Charles General Hospital</i> | | | 4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)
A. STATE <i>Md.</i> 8. COUNTY <i>27-49</i> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN
<i>Balto.</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<i>1667 E. Cold Spring Lane</i> | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>3-4-74</i> | 9. AGE (In years last birthday)
<i>95</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>None</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Lithuania</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 13. FATHER'S NAME
<i>Joseph Bernatow</i> | | 14. MOTHER'S MAIDEN NAME
<i>Catherine</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>215-03-5622</i> | | 17. INFORMANT, ADDRESS
<i>Terese Young Same</i> | |
| 18. <i>412.4</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
<i>from heart</i>
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Cerebrovascular vascular accident to rt. hemiplegia</i>
(B) <i>Atherosclerotic cardiovascular disease</i>
(C) _____ | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>May 17 1969</i> to <i>May 29 1969</i> , that (I) (we) last saw the deceased alive on <i>May 29 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Aurora T. Hipolito, M.D.</i> | | | | 23B. DATE SIGNED
<i>5/29/69</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>AURORA T. HIPOLITO, M.D.</i> | | | | 23D. ADDRESS
<i>North Charles Gen. Hosp.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6/2/69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Holy Redeemer</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 3 1969</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taber, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>Leonard J. Ruck Inc. Baltimore, Maryland</i> | |

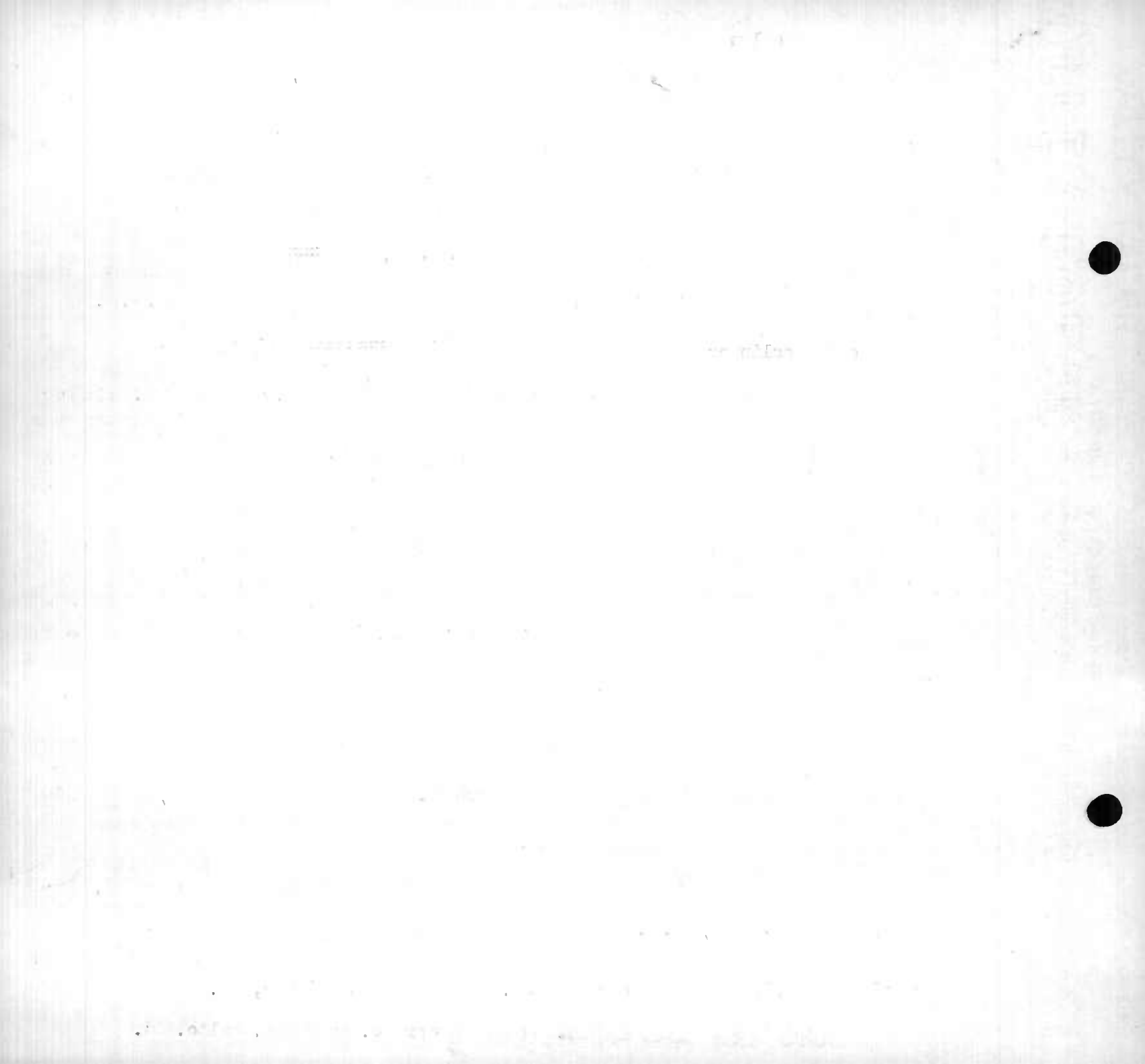


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5586 | |
|--|---------------------|---|---|--|---|
| BIRTH NO. Roslyn 69 5586 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Frederick Esslinger | | | 2. DATE AND HOUR OF DEATH
May 30, 1969 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

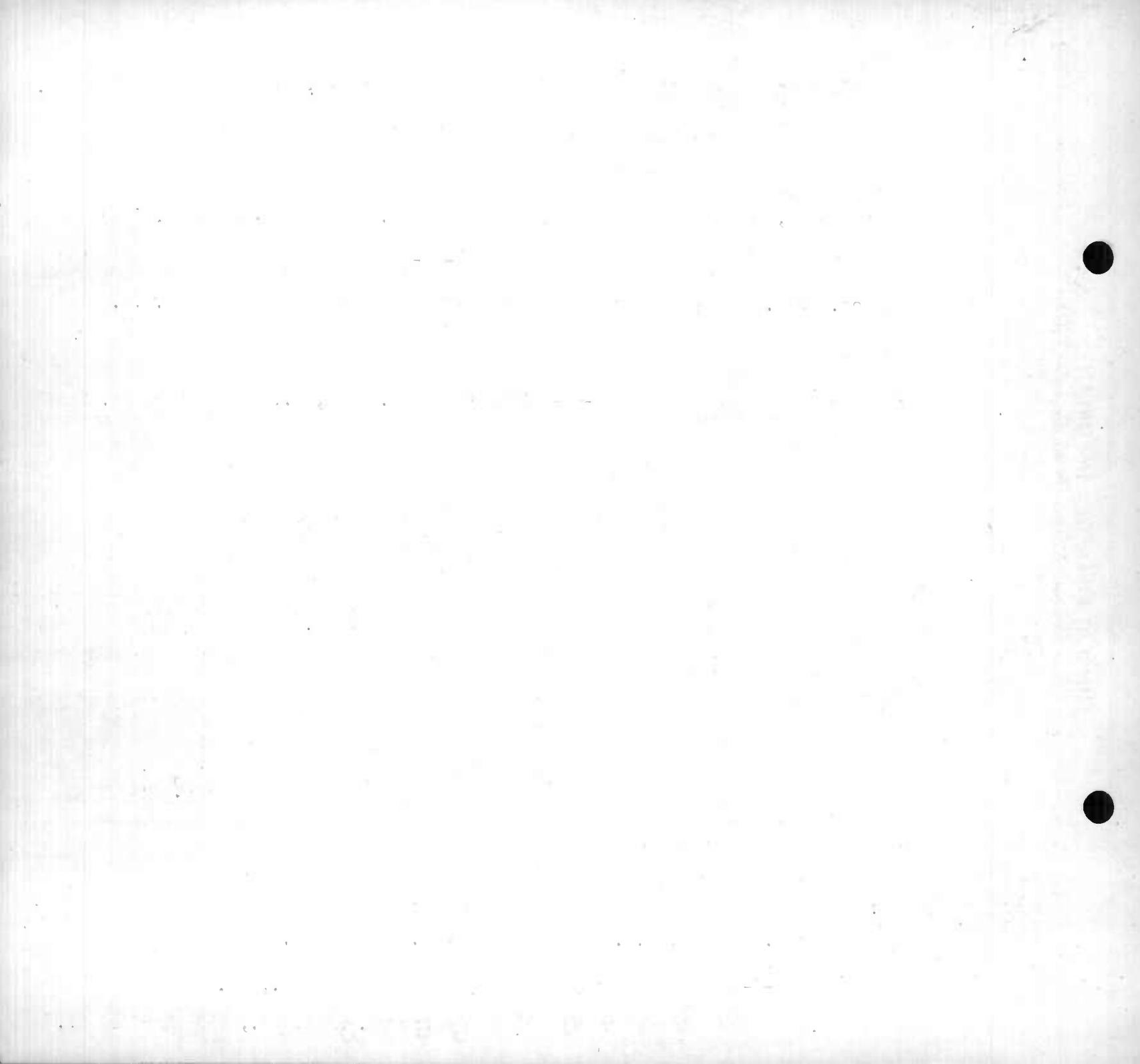
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Good Samaritan Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore City
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1111 Carroll Street 21230 | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 1, 94 | | 9. AGE (In years lost birthday) 74 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Brushmaker | | 10B. KIND OF BUSINESS OR INDUSTRY
Paint Brushes | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
Louis Esslinger | | |
| 14. MOTHER'S MAIDEN NAME
Rose Whaley | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes no or unknown) (If yes, give war or dates of service)
Yes World-War I | | |
| 16. SOCIAL SECURITY NO.
213-10-8716 | | 17. INFORMANT
Donald Esslinger son ADDRESS
2715 Baurenwood Ave. 21234 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
412.31 Disease Arteriosclerotic Heart | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 years | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| (C) _____ | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Cerebral arteriosclerosis | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from March 3, 1969 to May 30, 1969 , that (X) (we) last saw the deceased alive on May 30, 1969 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Michael Colvin, M.D. | | | | 23B. DATE SIGNED
May 30, 1969 | |
| 23C. PHYSICIAN'S NAME (Type)
Michael Colvin, M.D. | | | | 23D. ADDRESS
Good Samaritan Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/3/69 | | 24C. NAME of CEMETERY or CREMATORY
Meadowridge Mem. Park | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR
James E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Leonard J. Buck Inc. Balto. Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | | |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) <u>Eileen Marie Boswell</u> | | | | 2. DATE AND HOUR OF DEATH
<u>May 29, 1969</u> <u>1</u> <u>A.</u> M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>27-11</u> | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>4516 North Charles Street</u>
<u>Apartment F</u>
<u>Baltimore, Maryland 21210</u> | | | | C. CITY OR TOWN
<u>Baltimore</u> | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER
<u>4516 N. Charles Street Apt. F</u> | | | | | | | |
| 5. SEX
<u>Female</u> | | 6. RACE
<u>Caucasian</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>4-21-98</u> | | 9. AGE (In years last birthday)
<u>71</u> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Vice Pres. ret.</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Oles Envelope</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>Frederick Kirby</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>215-03-6526</u> | | 17. INFORMANT
<u>Charles G. Shaw, Jr., 201 Sudbury Ct. 21093</u> | | | | ADDRESS | |
| 18. <u>410.01</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Myocardial infarction</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, any, which rise to the above cause or state the UNDERLYING CONDITION last
<u>hypertensive arteriosclerotic cardiovascular disease</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>Emphysema and Asthmatic bronchitis</u> | | | | CAUSE OF DEATH
A. IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>hypertensive arteriosclerotic cardiovascular disease</u>
B. DUE TO, OR AS A CONSEQUENCE OF:
<u>Emphysema and Asthmatic bronchitis</u>
C. DUE TO, OR AS A CONSEQUENCE OF:
<u>Emphysema and Asthmatic bronchitis</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>instantaneous</u> | | | |
| 19A. DATE OF OPERATION
<u>6-2-69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<u>Lee E. Gresser M.D.</u> ^{EFW}
OEGREE | | | | 23B. DATE SIGNED | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Lee E. Gresser, M.D.</u> ^{OEGREE} | | | | 23D. ADDRESS
<u>4502 N. Charles St.</u> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6-2-69</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Moreland</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Balto., Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u> | | ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5588 |
|--|--|---|--|--|
| BIRTH NO. | | 69 5588 | | |
| 1. NAME OF DECEASED
(Type or Print) EMMA C. THIEL | | 2. DATE AND HOUR OF DEATH
5/31/69 1:55 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
48 Md. General Hospital | | C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER
3314 Echodale Avenue | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-27-92 | 9. AGE (In years last birthday) 77 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Md. |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Herman Kaschner | | |
| 14. MOTHER'S MAIDEN NAME
Anna Trahe | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO.
215-32-1055 B | | 17. INFORMANT
Hospital I.D. sheet | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
412.414E887X | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
ASCVD | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF:
Chronic brain syndrome = | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Chronic brain syndrome = | | |
| II | | Other significant conditions contributing to the death but not related to the terminal disease or condition given in Part I (A). | | |
| 19A. DATE OF OPERATION
5-4-69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Fx. L.h.p | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
3314 Echodale Ave |
| 21D. TIME OF INJURY (APPROX.)
5-3-69 | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
fall |
| 22. I certify that (I) (this hospital) attended the deceased from 5-3-69 to 5-31-69 , that (I) (we) last saw the deceased alive on 5-31-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Marvin C. Sachs, MD | | | | 23B. DATE SIGNED
5-31-69 |
| 23C. PHYSICIAN'S NAME (Type)
MARVIN C. SACHS, MD | | | | 23D. ADDRESS
Md - Gen. Hosp |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
6/3/69 | 24C. NAME OF CEMETERY or CREMATORY
Cedar Hill Cemetery | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR
Robert E. Faber, MD | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. | ADDRESS
5305 Harford Road 21214 | |

2

EMMA C. T. 10

1st General Meeting

F W

x

1st General Meeting

1st General Meeting

1st General Meeting

1st General Meeting

1st General Meeting

1st General Meeting

1st General Meeting

1st General Meeting

1st General Meeting

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1st General Meeting

1st General Meeting

1st General Meeting

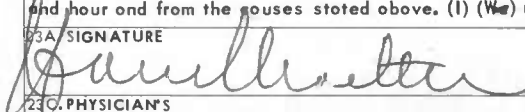
1st General Meeting

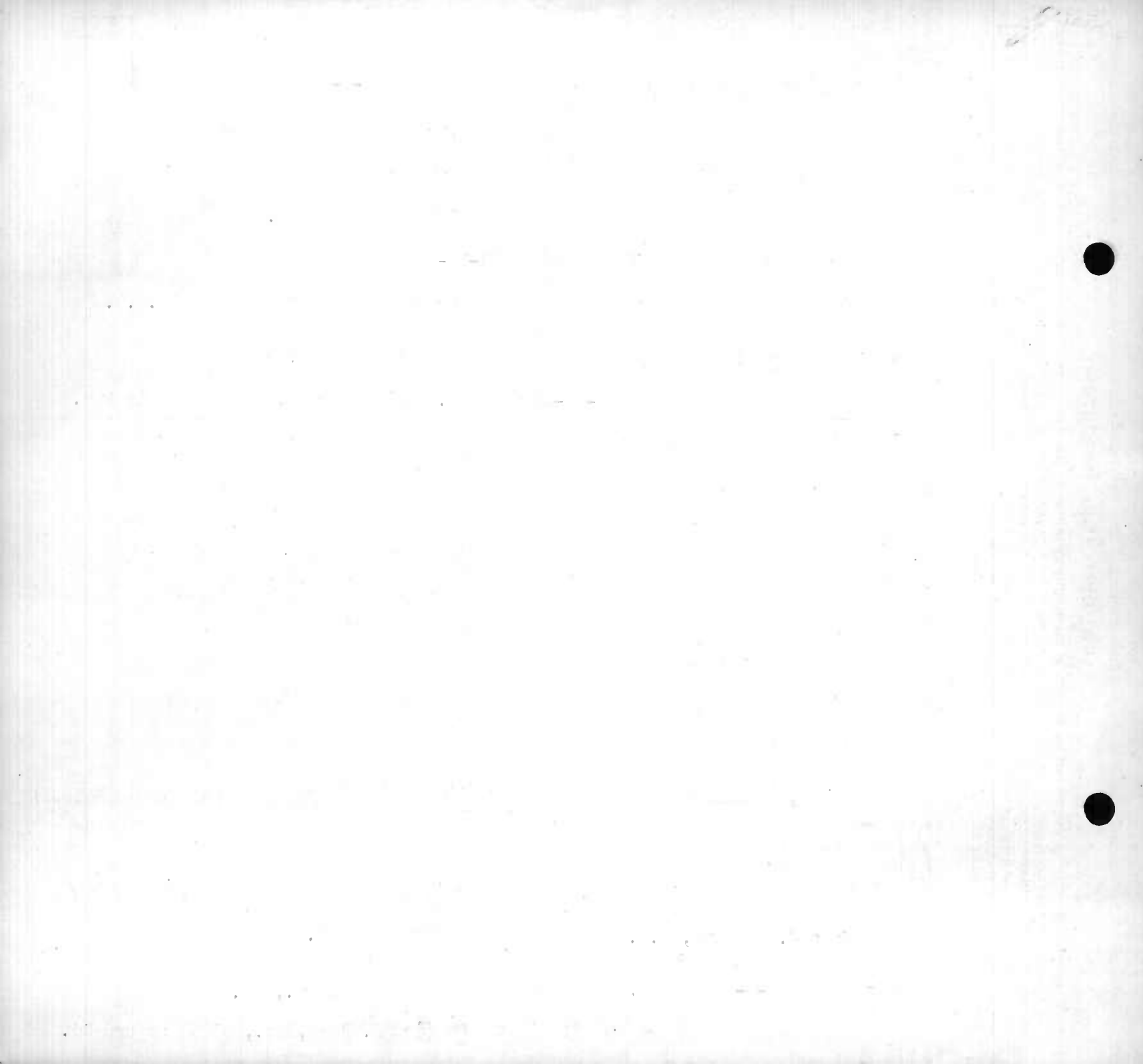
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5589

| | | | | | | | |
|--|-----------------------------|---|--|--|--|---|---------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Rose Theresa Klos | | 2. DATE AND HOUR OF DEATH
6-1-69 | | M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland 8. COUNTY 27-44 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
90 Gould Convalesarium | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
3108 Echodale Ave. | | | |
| 5. SEX
Female | 6. RACE
Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8-20-87 | 9. AGE (In years lost birthday)
81 | If Under 1 Yr.
Months: Days: Hours: Min. | If Under 24 Hrs.
Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Stanley Rodowski | | | | 14. MOTHER'S MAIDEN NAME
Theresa Franciskowski | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
215-54-2356 | | 17. INFORMANT ADDRESS
Mrs. Amelia Hartka, 3108 Echodale Ave. | |
| 18. 412.42250.9
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
Cerebral vascular accident
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
3 days
(B) Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF:
Many years
(C) and cerebral sclerosis
Many years | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Diabetes mellitus | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 3rd 1959 to June 1 1969 , that (I) (we) last saw the deceased alive on May 16th 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death. | | | | | | | |
| 23A. SIGNATURE
 | | | | 23B. DATE SIGNED
6/2/69 | | 23C. PHYSICIAN'S NAME (Type)
Hans J. Koetter, M.D. | |
| 23D. ADDRESS
5600 Harford Rd. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-5-69 | | 24C. NAME OF CEMETERY or CREMATORY
St. Stanislaus | | 24D. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Stuber, Jr. | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Buck, Inc., 5305 Harford Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 69 5590 | |
|--|--|--|--|--|--|--|--|
| BIRTH NO. 69-04760 69 5590 | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH 5/31/69 | | 3-20 PM. | |
| 1. NAME OF DECEASED (Type or Print) BABY BOY KOHLBAUER DWYANE EDWARD KOHLBAUER | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. CO. 53-00 | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSP. BALTO, MD, 21218 | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 5. SEX male | | 6. RACE caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-28-69 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) 4 | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME ALPHEUS W. KOHLBAUER | | 14. MOTHER'S MAIDEN NAME PATRICIA ANN SCHMIDT | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT FATHER | | ADDRESS SAME. | |
| 18. 776.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Anoxia (B) Fetal Distress. (C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 weeks Intoxication. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/28 19 69 to 5/31 19 69, that (I) (we) last saw the deceased alive on 5/31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Antonio Q. Chan, M.D. | | | | 23B. DATE SIGNED 5/31/69 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. ANTONIO CHAN MD. | | | | 23D. ADDRESS UNION MEM. HOSP. BALTO. MD. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE June 2, 1969 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 3 1969 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Luck, Inc. - Balto, Md. - 14 | | ADDRESS | |

WILLIAMSON



WILLIAMSON

WILLIAMSON

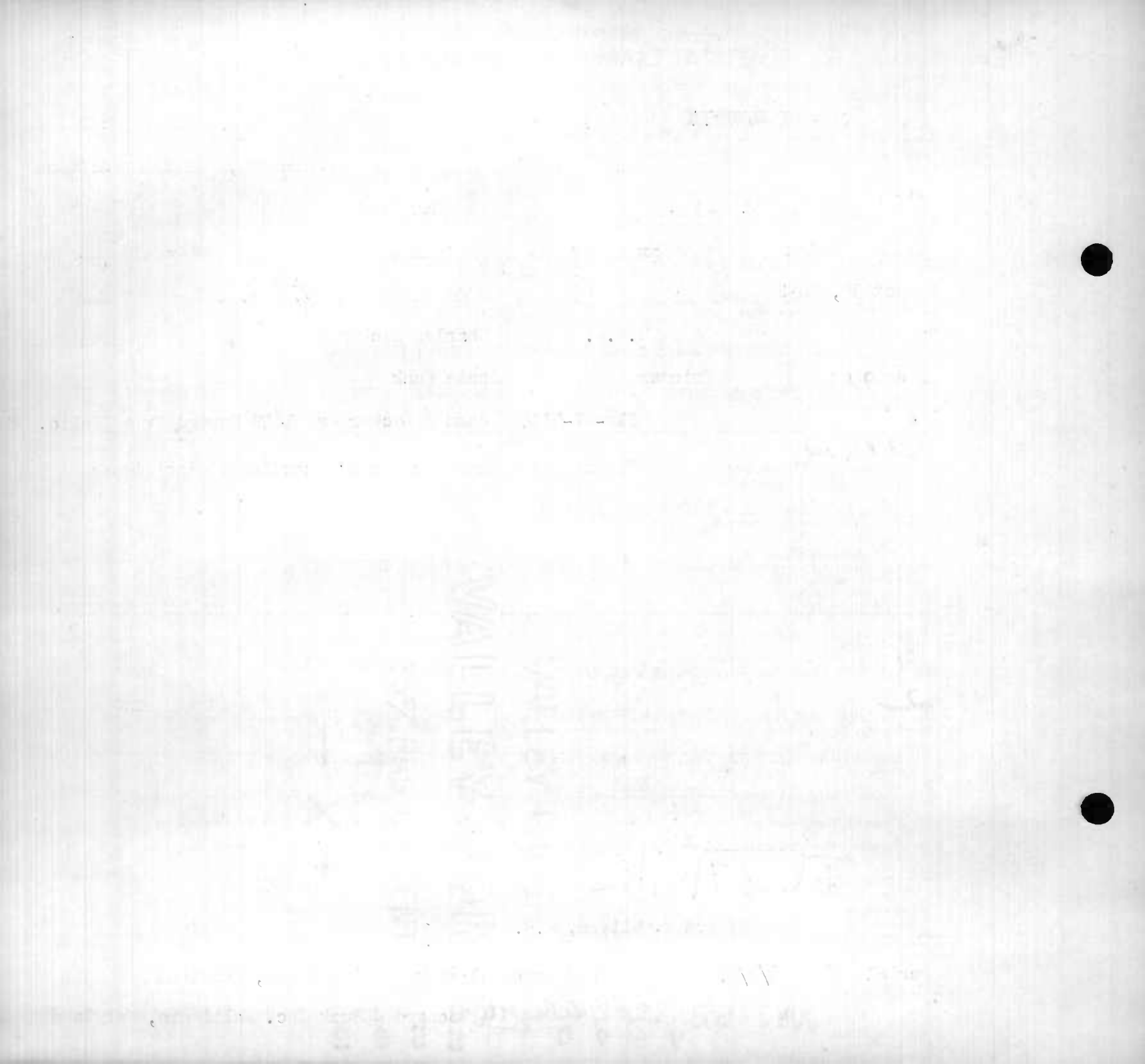
WILLIAMSON

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
JOHN LOCKER LUCKER, SR. | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
6 1 69 4:19 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
00 5003 Lodestone Wy. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 1, 1969 5:10 a.m. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
August 30, 1892 | | 10. AGE (In years lost birthday)
76 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Inspector | | 14B. KIND OF BUSINESS OR INDUSTRY
Printer | |
| 15. MOTHER'S MAIDEN NAME
Annie Funk | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 17. SOCIAL SECURITY NO.
216-07-0116 | | 18. INFORMANT
John F Lucker Jr | |
| 19. CAUSE OF DEATH
Hypertensive arteriosclerotic cardiovascular disease | | ADDRESS
1612 Howard Ave Balto. Md | |
| 20A. DATE OF OPERATION
4/12/21 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
YES | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 6/1/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/4/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Moreland Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Talbot, M.D. | |
| 25C. FUNERAL DIRECTOR
Leonard J Ruck Inc. | | ADDRESS
Baltimore, Maryland | |



B-630

69 5592 BALTIMORE CITY HEALTH DEPARTMENT

69 5592

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
MARY ETHEL BRADY | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> 5 31 69 6:00 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
44 Union Memorial Hospital | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 31, 1969 6:00 a.m. | |
| 6. SEX
Female | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
2/27/1896 | | 10. AGE (In years lost birthday) 73 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 14B. KIND OF BUSINESS OR INDUSTRY
Nurse | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO.
212-32-0073 | |
| 18. INFORMANT
Edward J. Huber 7 Pheasant Dr. Elkridge Md | | ADDRESS
Elkridge Md | |
| 19. E812.0
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Craniocerebral injuries | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION
0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
Intersection of Belvedere & 27th | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)
5 27 69 10:50 m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Driver in auto - auto coll. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED May 31, 1969 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/3/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Leonard J. Buck Inc. | |
| 25C. FUNERAL DIRECTOR
5305 Harford Road 21214 | | ADDRESS | |

2/15/12

Amesbury

Amesbury

10-20-12

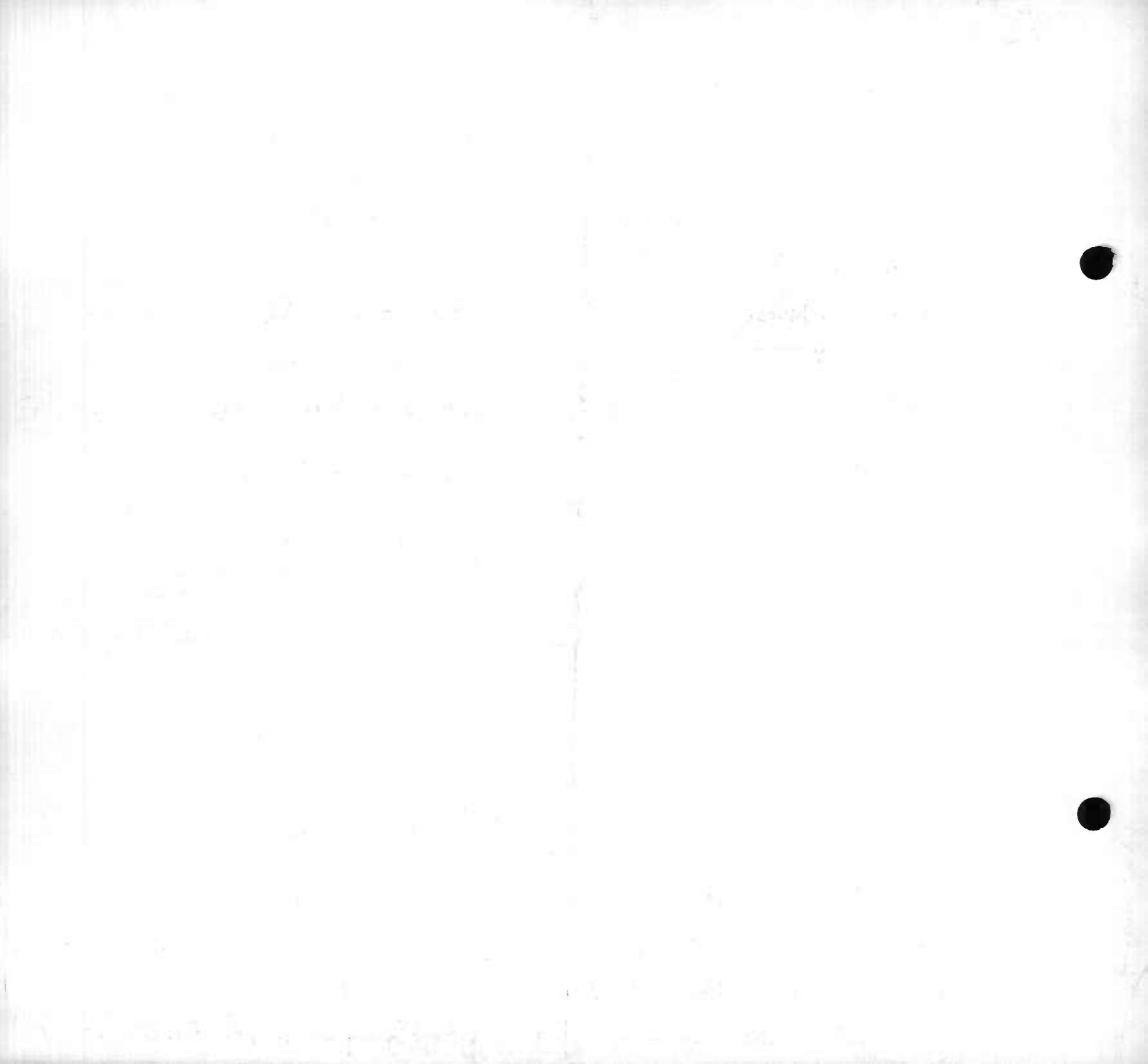
— 2/15/12 —

17

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------|---|--|---|---|---|--|
| 69 5593 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 69 5593 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Klunk, Charlotte E | | 2. DATE AND HOUR OF DEATH
5/30/69 3:30 pm | | M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE PA B. COUNTY Hanover | | C. CITY OR TOWN Hanover | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Johns Hopkins Hospital
601 N. Broadway
Baltimore, Maryland 21205 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER
3 Grandview Rd | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10-17-99 | 9. AGE (in years last birthday)
69 years | 10. Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Registered Nurse | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
Hanover, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HARRY KUHN | | 14. MOTHER'S MAIDEN NAME
ALICE LOOKINBAUGH | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
W.M.J. Kuhn. | | ADDRESS
Hanover RDs Pa | | 18. CAUSE OF DEATH
I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
Sepsis + Uremia
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) Cancer of Bladder with metastasis and fistula
(C) Uremia - Azotemia - Acidosis Sepsis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 19A. DATE OF OPERATION
2. none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 19A. DATE OF OPERATION
2. none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/18/69 to 5/30/1969 that (I) (we) last saw the deceased alive on 5/30 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
H. Semerdjian M.D. DEGREE | | 23B. DATE SIGNED
5/30/69 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Hrant S. Semerdjian M.D. DEGREE | | 23D. ADDRESS
1620 Mc Elderry St Balto MD 21205 | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
June 2, 1969 | |
| 24C. NAME OF CEMETERY or CREMATORY
ST. Joseph Cem. | | 24D. LOCATION (City, town, or county) (State)
Hanover YORK Pa. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor M.D. | |
| 25C. FUNERAL DIRECTOR
J. F. Elmer Sons Rustertown Md | | ADDRESS | | 25D. DATE | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5594

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 5594

| | | | | | |
|---|-------------------------|---|---|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Stanton, Enoch</u> | | 2. DATE AND HOUR OF DEATH
<u>May 29, 1969 1:15 P.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> | | C. CITY OR TOWN <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>George Washington Nursing Home</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Dec. 12 1910</u> | 9. AGE (In years last birthday)
<u>58</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>unknown</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>unknown</u> | | 11. BIRTHPLACE (State or foreign country)
<u>North Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | 13. FATHER'S NAME
<u>UNKNOWN</u> | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>UNKNOWN</u> | | 17. INFORMANT
<u>HAYWOOD LINDSAY</u> | |
| ADDRESS
<u>3028 TIOGA PKWY</u> | | 18. CAUSE OF DEATH | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>UREMIA</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 WKS.</u> | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | <u>GASTRIC CARCINOMATOSIS</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>GI BLEEDING</u> | | | |
| (C) <u>ANEMIA, DEHYDRATION</u> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<u>5-28-69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>5-28-1969</u> to <u>5-29-1969</u> , that (2) (we) last saw the deceased alive on <u>5-29-1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Richard Tyson</u> | | 23B. DATE SIGNED
<u>5-29-69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>RICHARD TYSON</u> | |
| 23D. ADDRESS
<u>2320 EUTAW PL (CITY 17)</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | | |
| 24B. DATE
<u>6-2-69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>MT. AUBURN CEM.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTO. CITY, MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Bailey, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Marshall W. Jones, JR.</u> | |
| ADDRESS
<u>1735 HARFORD AVE</u> | | | | | |

72 1910
The following is a list of the
names of the persons who
were present at the
meeting of the
Board of Directors
of the
Company held on
the 10th day of
January, 1910.

FUNERAL DIRECTOR: IMPORTANT

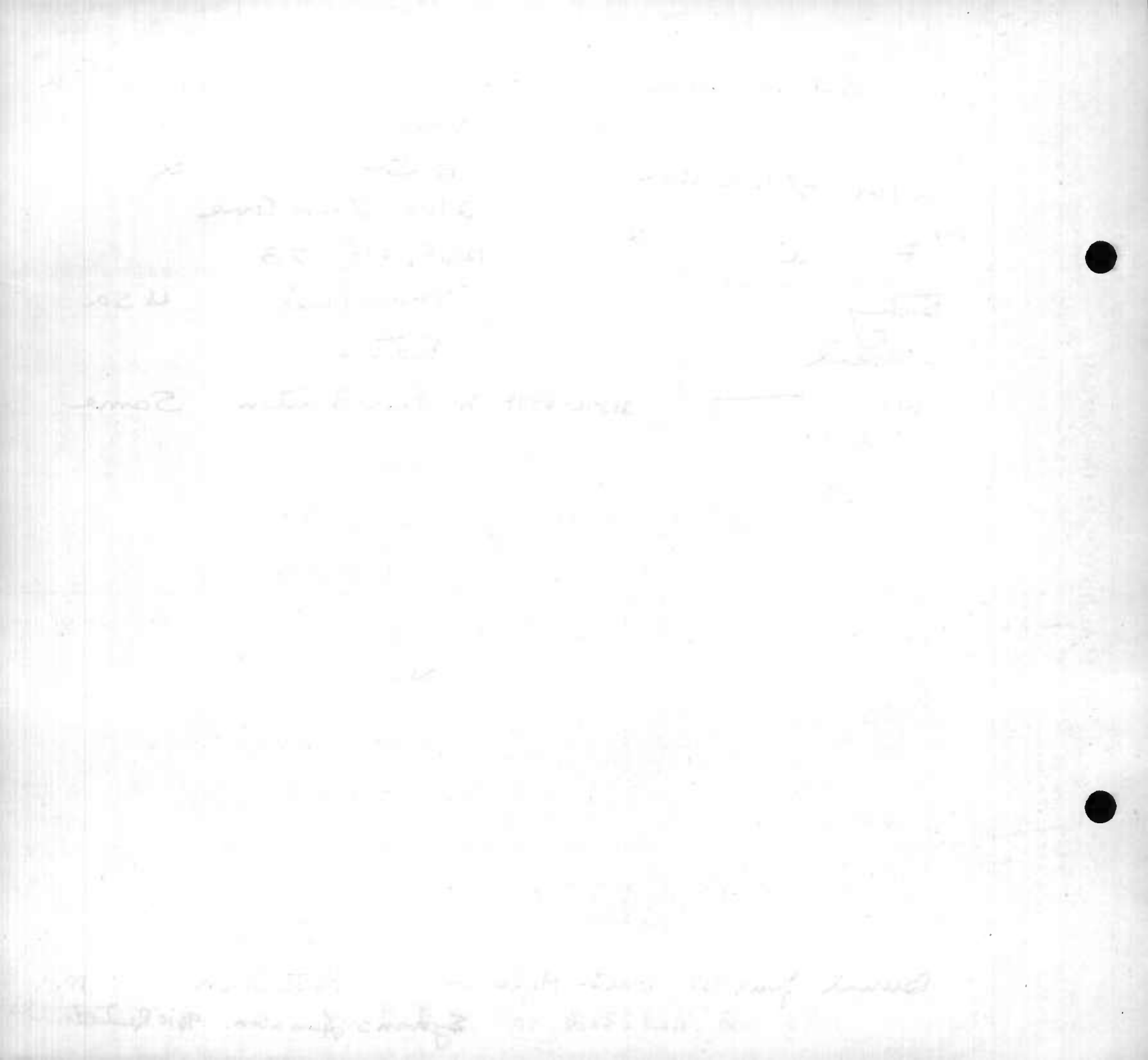
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5595

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5595

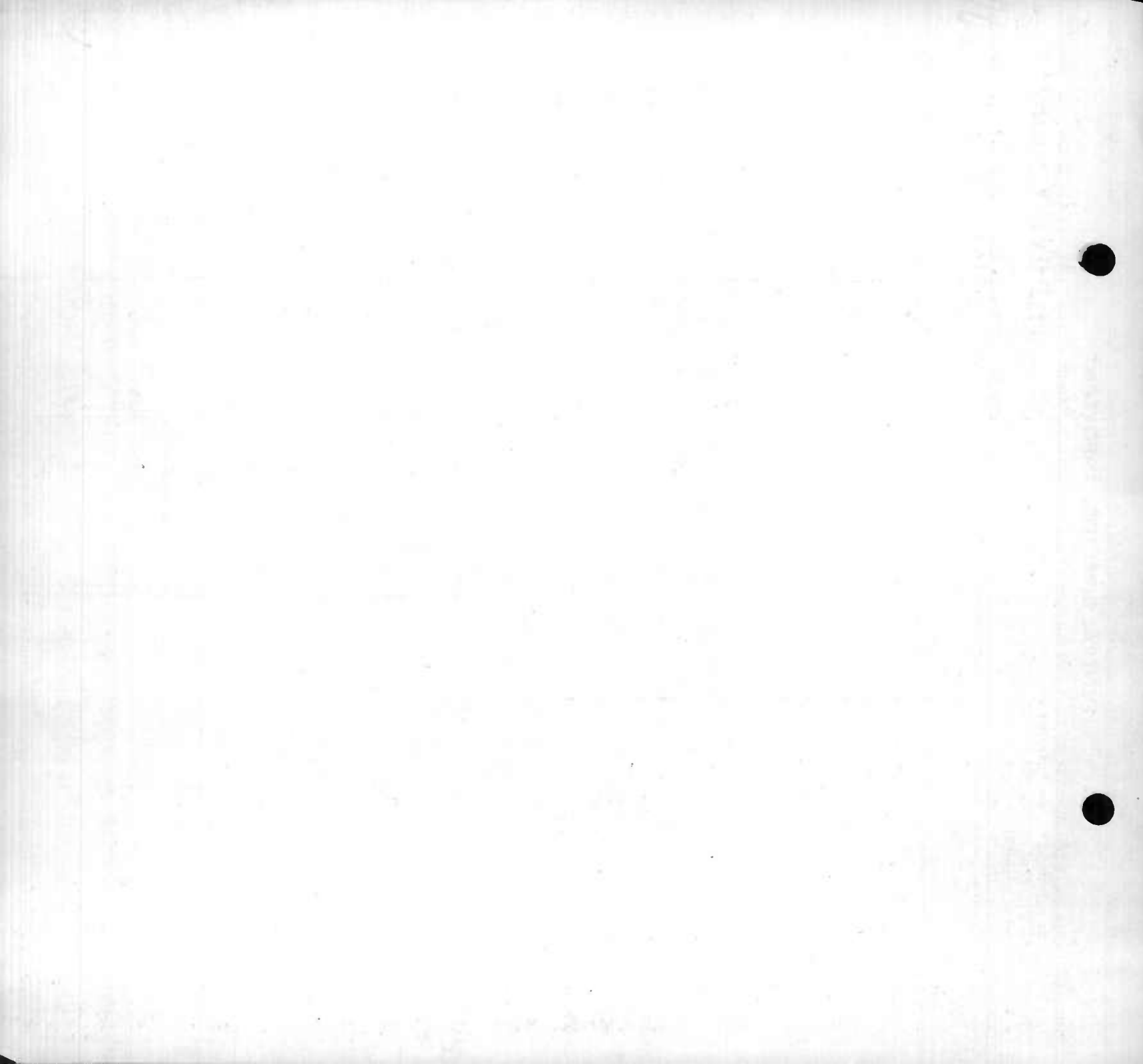
| | | | | | |
|---|---------------------|---|---------------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Esther Selma Bernstein</i> | | 2. DATE AND HOUR OF DEATH
<i>5/30/1969 12²⁵ a M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>md</i> B. COUNTY <i>27-40</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>2906 Glen Ave</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<i>Balto</i> | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
<i>2906 Glen Ave</i> | | | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>12/25/1895</i> | 9. AGE (in years last birthday)
<i>73</i> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Seeding</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | | |
| 13. FATHER'S NAME
<i>Israel</i> | | 14. MOTHER'S MAIDEN NAME
<i>Katie</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | 16. SOCIAL SECURITY NO.
<i>213-16-6894</i> | | 17. INFORMANT
<i>Mr. Paul Bernstein</i> | |
| | | | | ADDRESS
<i>Same</i> | |
| 18. <i>153.8 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>CONGESTIVE HEART FAILURE</i>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>6 MOS</i>
(B) <i>METASTATIC CARCINOMA</i>
DUE TO, OR AS A CONSEQUENCE OF:
<i>18 MOS</i>
(C) <i>CARCINOMA OF COLON</i> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 HR</i> | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<i>II</i>
<i>PNEUMONIA</i> | | | | 20. DATE OF OPERATION
<i>NO</i> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>April</i> 19 <i>68</i> to <i>MAY 30</i> 19 <i>69</i> , that (1) (we) last saw the deceased alive on <i>MAY 30</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Bernard R. Mochet, MD</i>
DEGREE | | | | 23B. DATE SIGNED
<i>MAY 30, 1969</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>BERNARD R. MOCHET, MD</i>
DEGREE | | | | 23D. ADDRESS
<i>6804 PARK HEIGHTS AVE
BALTIMORE, MD 21215</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>June 1, 1969</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Balto Hebrew</i> | |
| 24D. LOCATION
<i>Reisterstown</i> | | | | (City, town, or county) (State)
<i>MD</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 3 1969</i> | | 25B. NAME OF REGISTRAR
<i>David E. Taylor, MD</i> | | 25C. FUNERAL DIRECTOR
<i>Sylvan S. Lins & Son</i> | |
| | | | | ADDRESS
<i>9610 Reisterstown Rd</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5596 | |
|---|--|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Louis Kaplan</i> | | 2. DATE AND HOUR OF DEATH
<i>5/31/1969 2:50 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>28-31</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>4145 Crest Heights Rd</i> | | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <i>M</i> 6. RACE <i>W</i> | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
<i>18 March 1900</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Ret</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Clerk</i> | | 9. AGE (In years last birthday)
<i>69</i> |
| 13. FATHER'S NAME
<i>Morris</i> | | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>092-09-8999A</i> | | 17. INFORMANT
<i>Lydia Kaplan</i> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>16211 I</i> | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<i>CARCINOMA OF LUNG</i>
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 months</i> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<i>NO</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb '69</i> 19 to <i>MAY '69</i> 19, that (I) (we) last saw the deceased alive on <i>MAY '69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Malcolm S. Druskin, M.D.</i> | | | | 23B. DATE SIGNED
<i>31 MAY 1969</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>MALCOLM S. DRUSKIN, M.D.</i> | | | | 23D. ADDRESS
<i>2217 SOUTH RD, BALTIMORE, Md. 21209</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6/2/69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>New Montpelier</i> | |
| 24D. LOCATION
<i>Long Island</i> | | 24E. CITY, TOWN, or COUNTY
<i>New York</i> | | 24F. STATE
<i>New York</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 3 1969</i> | | 25B. NAME OF REGISTRAR
<i>John E. Taylor, R.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Sylvan S. Lewis & Son, Inc</i> | |
| | | | | ADDRESS
<i>9610 Reisterstown Rd</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5597 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 5597

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Appel, Edna A.

2. DATE AND HOUR OF DEATH

6-1-69

1 3 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

Maryland General Hospital.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Balto

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4220 White Avenue

5. SEX

Female

6. RACE

White

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

5-9-94

9. AGE (In years last birthday)

75

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none title #19

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Bernard Appel

14. MOTHER'S MAIDEN NAME

E. Burndel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

214-40-4469

17. INFORMANT

Supr. Bolton Hill Wsg Home / Admiss. Record

ADDRESS

18. 250.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE: ? pulmonary Emboli
DUE TO, OR AS A CONSEQUENCE OF:

(B) Arteriosclerotic Cardiovascular disease, 2 years
DUE TO, OR AS A CONSEQUENCE OF:

(C) atrial fibrillation, congestive heart failure
Diabetes mellitus, old left 2 years

cerebrovascular accident.

post-left leg above knee Amputation - 4 days

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 day

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

5.27.69

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Gangrene left leg
arterial embolism

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

22. I certify that (I) (this hospital) attended the deceased from 5.22 1969 to 6.1 1969 that (I) (we) last saw the deceased alive on 6.1 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Mohammad Sidig

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6.1.69

23C. PHYSICIAN'S NAME (Type)

MOHAMMAD SIDIG M.B.S.

23D. ADDRESS

Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

June 4-1969

24C. NAME OF CEMETERY OR CREMATORY

Balto Cemetery

24D. LOCATION

BALTO

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 3 1969

25B. NAME OF REGISTRAR

Wm E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ONE TO EVANS Tm 8802 that said R

ADDRESS

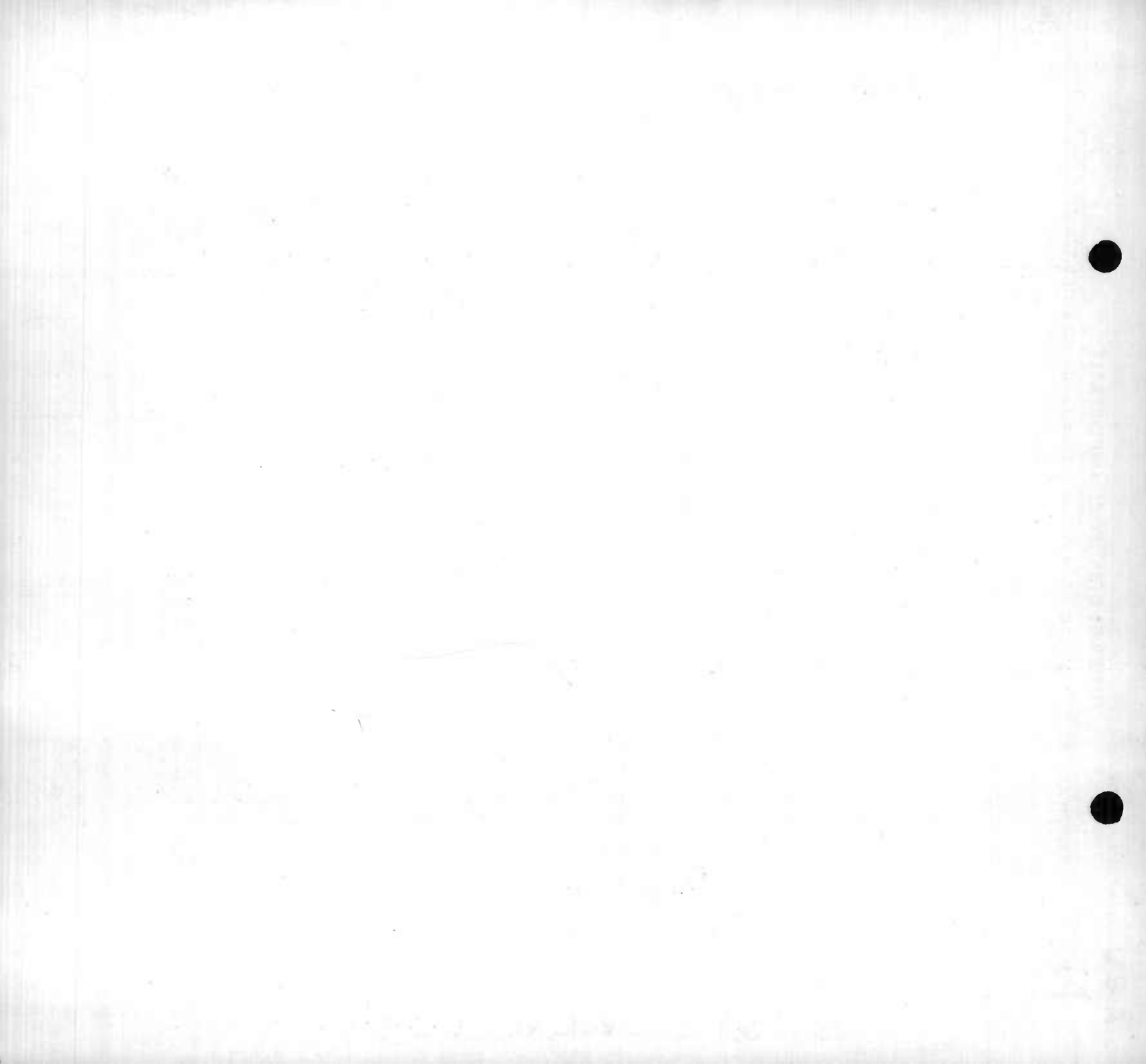
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 5598 CERTIFICATE OF DEATH

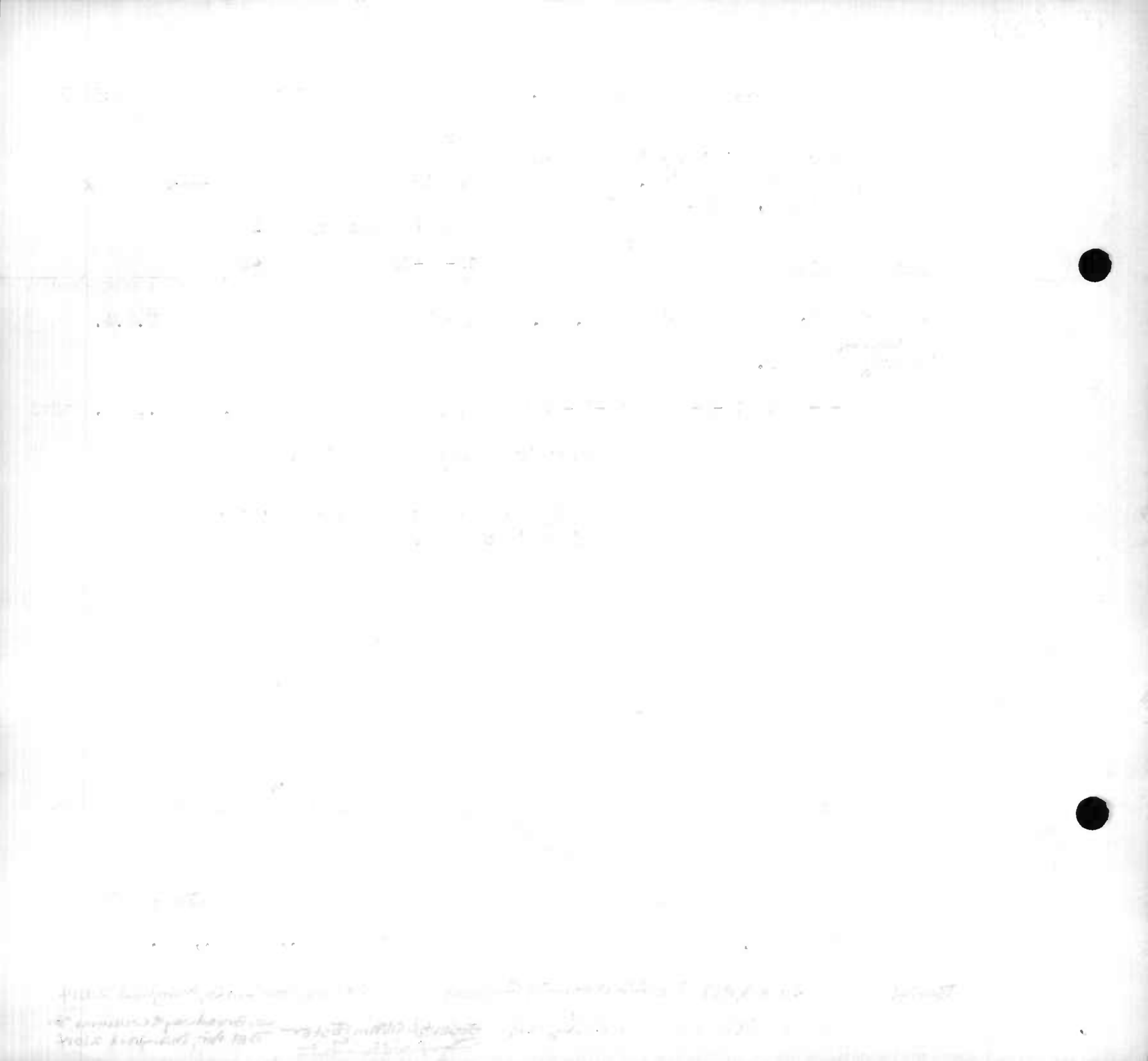
REG. NO. 69 5598

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or print) Kordek Louis F. | | 2. DATE AND HOUR OF DEATH
June 1, 1969 7:15 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 2-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Bon Secours Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 5-11-03 | | 9. AGE (In years last birthday) 66 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer Chemical | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New York | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Frank Kordek | | 14. MOTHER'S MAIDEN NAME Rosalie Kozlowski | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-10-3486 | | 17. INFORMANT Mrs. Marie Kordek, Chart ADDRESS 2008 Spark Court | |
| 18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Cerebral Hemorrhage | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
H.A.S.C.V.D. | | (B) DUE TO, OR AS A CONSEQUENCE OF:
YEARS | |
| (C) GENERALIZED ARTERIOSECTE | | | | YEARS | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from May 31, 1968 to June 1st, 1969 , that (I) (we) last saw the deceased alive on June 1st, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above on (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Agustin del Campo MD DEGREE | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED June 1st 1968 | |
| 23C. PHYSICIAN'S NAME (Type) AGUSTIN del CAMPO MD | | 23D. ADDRESS BON SECOURS HOSP BALTIMORE MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/4/69 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 3 1969 | | 25B. NAME OF REGISTRAR Wm E. Fisher, MD | | 25C. FUNERAL DIRECTOR M. F. SADOWSKI & SONS, 1808 EASTERN AVE ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|
| 69 5599 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 69 5599 | |
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) YEWELL, RICHARD WARREN JR. | | | | May 31 1969 6:50 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION
Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, Maryland 21218 | | | | A. STATE
Maryland | | B. COUNTY
Harford | |
| | | | | C. CITY OR TOWN
Belair | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
Male | | | | 6. RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Computer Tech. | | | | 10B. KIND OF BUSINESS OR INDUSTRY
American Tot. Co. | | 8. DATE OF BIRTH
12-21-20 | |
| 13. FATHER'S NAME
Richard Yewell Sr. | | | | 14. MOTHER'S MAIDEN NAME
Mabel Standiford | | 9. AGE (in years last birthday)
48 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 6-6-39 to 10-3-43 | | | | 16. SOCIAL SECURITY NO.
217-26-2299 | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 17. INFORMANT
Records | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | ADDRESS
VAH, 3900 Loch Raven Blvd. Balto., Md. 21218 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
492 X I
Congestive Heart Failure Right Side
Decompensated
Emphysema with Diffuse Interstitial Fibrosis of Lungs | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. DATE OF OPERATION
21 | | | | 20. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from May 27 19 69 to May 31 19 69 that (we) last saw the deceased alive on May 31 19 69 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
V.B. Mulay | | | | 23B. DATE SIGNED
JUNE 1, 1969 | | 23C. PHYSICIAN'S NAME (Type)
VISHNU B. MULAY MD | |
| 23D. ADDRESS
3900 Loch Raven Blvd., Balto., Md. 21218 | | | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | |
| 24B. DATE
JUNE 3, 1969 | | | | 24C. NAME OF CEMETERY OR CREMATORY
BEL AIR MEMORIAL GARDENS | | 24D. LOCATION (City, town, or county) (State)
BEL AIR, HARFORD CO, MARYLAND 21014 | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | | 25B. NAME OF REGISTRAR
W. E. Talbot, M.D. | | 25C. FUNERAL DIRECTOR
Joseph William Foster | |
| | | | | ADDRESS
W. Broadway & Carrolls St. BEL AIR, Maryland 21014 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5600 |
|--|--|---|--|---|
| BIRTH NO. 69 5600 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) C. Charles Frederick | | 2. DATE AND HOUR OF DEATH
May 29, 1969 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
3616 Elkador Road | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 9-03
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3616 Elkador Road | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/31/1900 | 9. AGE (In years last birthday) 69 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bookkeeper (retired) | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Charles H. Frederick | | 14. MOTHER'S MAIDEN NAME
Elizabeth M. Schneider | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-09-9334A | 17. INFORMANT
Mrs. Florence B. Frederick ADDRESS Rd. 3616 Elkador | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Metastatic Carcinoma to Regional Area, Lung
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Epidermoid Carcinoma, Neck, Unknown Primary | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
16 mos.
(B) DUE TO, OR AS A CONSEQUENCE OF:
26 mos.
(C) _____ | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 19 67 to May 19 69 , that (I) (we) last saw the deceased alive on May 20 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Wm. H. Kammer, Jr. | | 23B. DATE SIGNED
31 May 1969 | | 23C. PHYSICIAN'S NAME (Type)
John A. Moran, Inc. |
| 23D. ADDRESS
6011 York Rd. Balt. Md. 21212 | | 23E. DATE REC'D BY HEALTH DEPT. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/2/69 | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland |
| 25A. NAME OF REGISTRAR
John A. Moran, Inc. | | 25B. FUNERAL DIRECTOR ADDRESS
3000 E. Baltimore St | | |

WELBY DIRECTOR

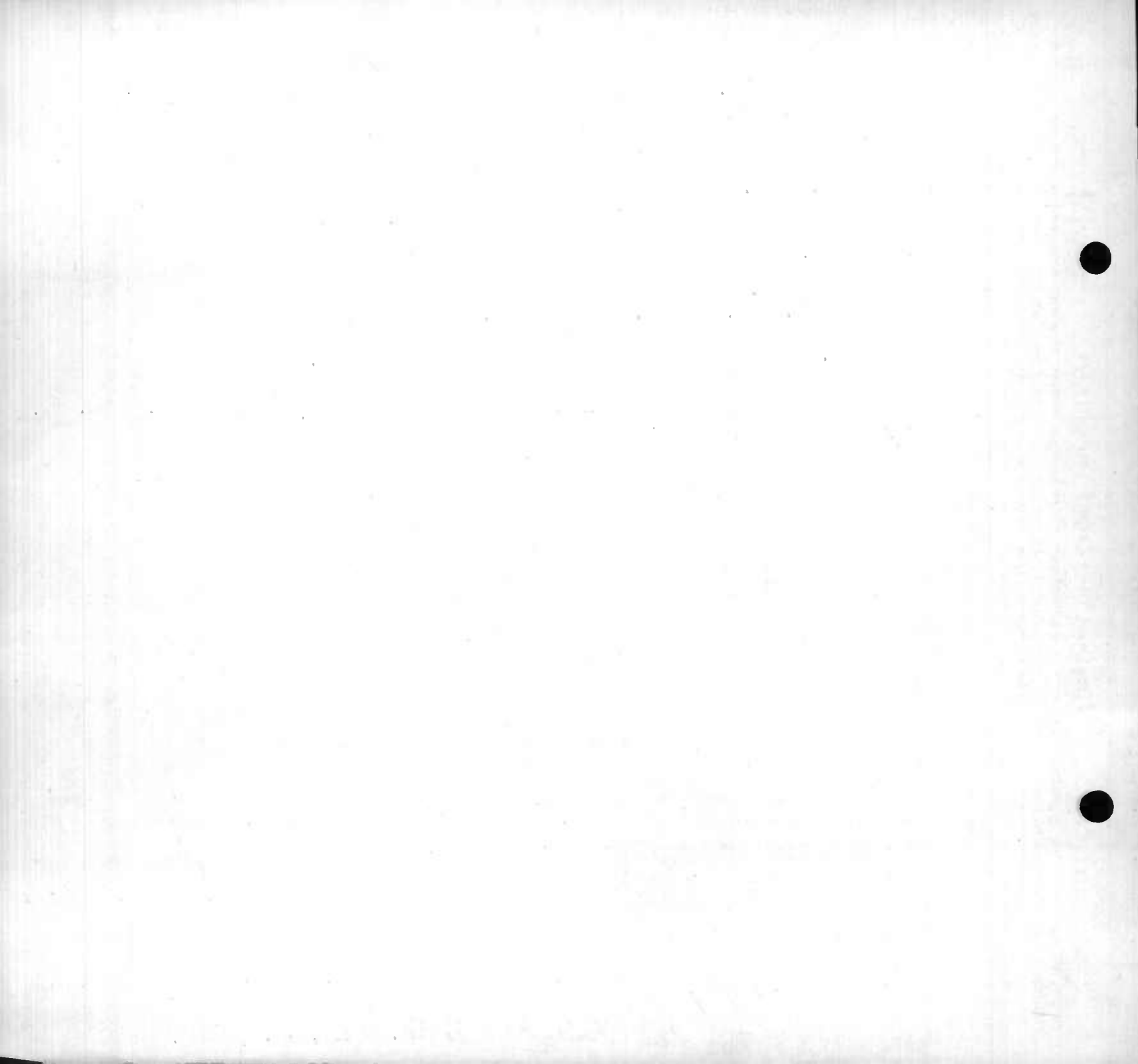


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|----------------------|---|--|--|---|--|---|------------------------------|--|
| 69 5601 | | | | | REG. NO. 69 5601 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. | | | | | DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Robert M. Pryor</i> | | | | | 2. DATE AND HOUR OF DEATH
<i>May 29, 1969 10:00 4 M.</i> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>503 E. 41st. Street</i> | | | | | A. STATE
<i>Maryland</i> | | B. COUNTY
<i>9-01</i> | | |
| | | | | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER
<i>503 E. 41st. Street</i> | | | | | | | | | |
| 5. SEX
<i>M.</i> | 6. RACE
<i>W.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>1/21/1999</i> | 9. AGE (In years last birthday)
<i>70</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired Ass't. Sec.</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Balto. Police Dept.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | |
| 13. FATHER'S NAME
<i>Mark W. Pryor</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Catherine F. Wilson</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>yes WWI</i> | | | 16. SOCIAL SECURITY NO.
<i>216-34-8088</i> | | 17. INFORMANT ADDRESS
<i>Mrs. Geraldine R. Pryor 503 E. 41st. St.</i> | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>16211 I</i> | | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Bronchogenic carcinoma 2yr.</i> | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<i>Arteriosclerotic Heart Disease</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>15yr.</i> | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 6, 1954</i> to <i>May 29, 1969</i> , that (I) (we) last saw the deceased alive on <i>May 22, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>Frederick J. Vollmer MD</i> | | | | | 23B. DATE SIGNED
<i>May 31, 1969</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>FREDERICK J. VOLLMER MD</i> | | | | | 23D. ADDRESS
<i>6100 YORK RD BALTO 21212</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6/3/69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Baltimore National Cemetery</i> | | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR
<i>Robert E. Gable, R.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>John A. Moran, Inc. 3000 E. Baltimore St</i> | | | | |

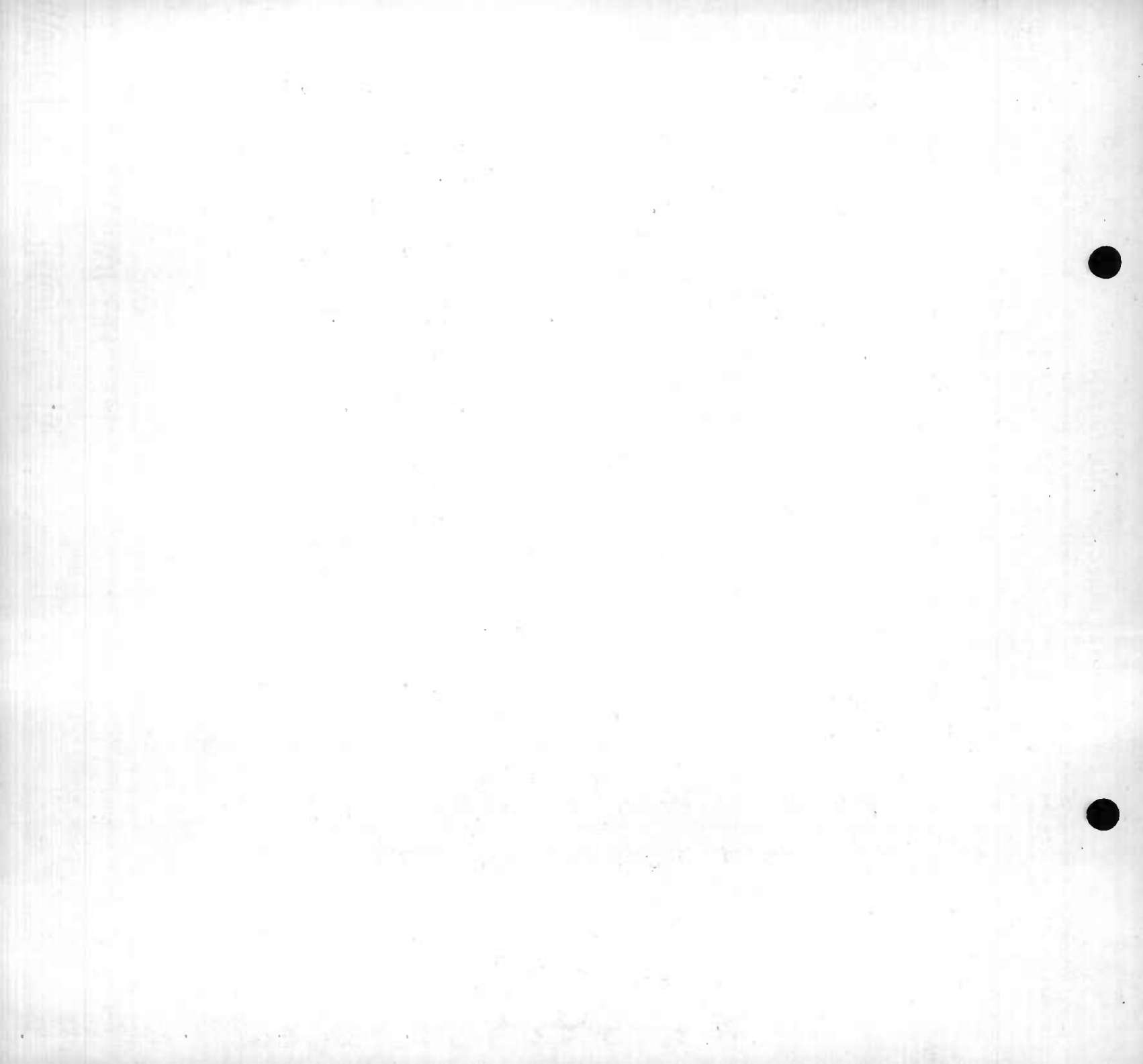
JUN 3 1969



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

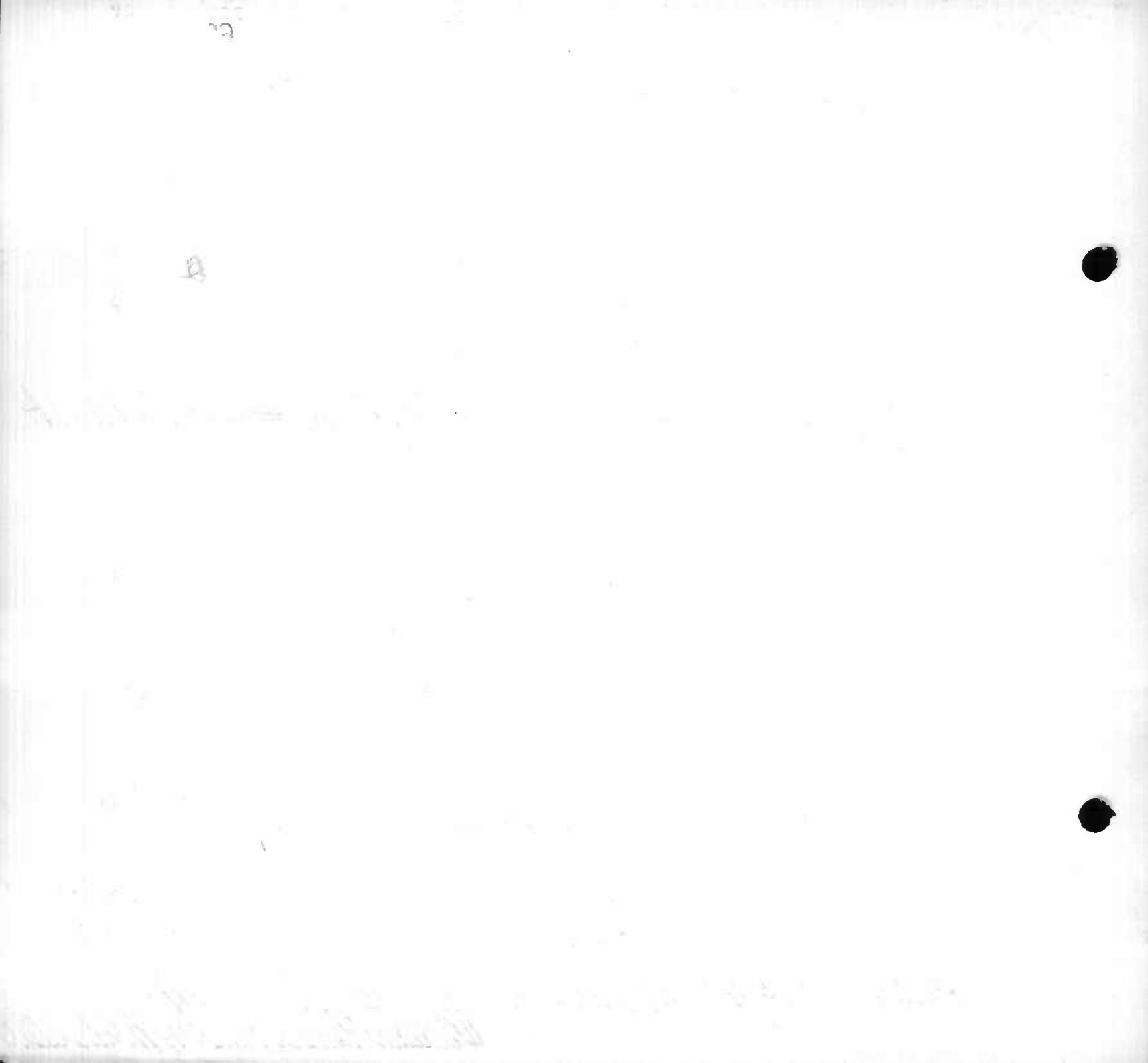
| | | | | | |
|---|---------------------|---|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>William Robb</i> | | 2. DATE AND HOUR OF DEATH
<i>June 2, 1969</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>00 5130 Chalgrove Ave.</i> | | | A. STATE <i>Maryland</i>
B. COUNTY <i>27-17</i> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<i>5130 Chalgrove Avenue</i> | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>11/14/196</i> | 9. AGE (In years last birthday)
<i>72</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>cutter (retired)</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Clothing Mfg.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Maryland</i> | |
| 13. FATHER'S NAME
<i>Guy H. Robb</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Anna Pachta</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>yes UN 1</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Mrs. Evelyn N. Robb</i> | |
| | | | | ADDRESS
<i>5130 Chalgrove Ave.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<i>436.01</i> | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Cerebral Vascular Accident</i>
(B) <i>Hypertension</i>
(C) _____ | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>June 2, 1969</i>
<i>May 16, 1969</i> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>None</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>none</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>May 16, 1969</i> to <i>June 2, 1969</i> , that (I) (we) last saw the deceased alive on <i>June 2, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Milton E. Lowman</i> | | | | 23B. DATE SIGNED
<i>June 2, 1969</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>MILTON E. LOWMAN</i> | | | | 23D. ADDRESS
<i>1401 REISTERSTOWN RD BALTO 21208 MD</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6/4/69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Baltimore National Cemetery, Baltimore, Maryland</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 3 1969</i> | | 25B. NAME OF REGISTRAR
<i>John J. Moran, Inc.</i> | |
| | | 25C. FUNERAL DIRECTOR
<i>John J. Moran, Inc.</i> | | ADDRESS
<i>3000 E. Baltimore St.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

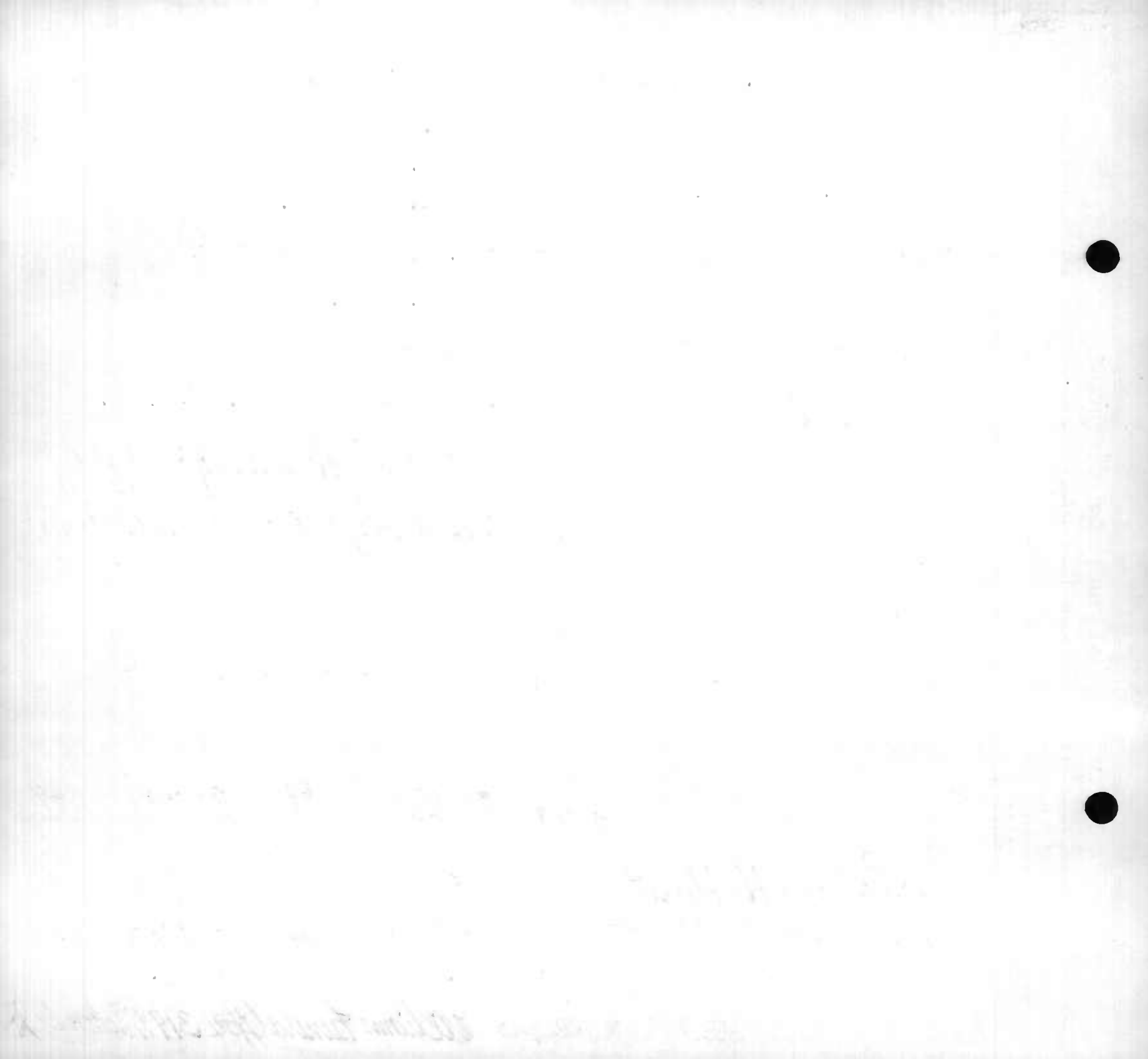
| | | | | |
|---|---|---|--|--|
| BIRTH NO. <u>69-4266</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>69 5603</u> |
| 1. NAME OF DECEASED
(Type or Print) <u>Warren Teal</u> | | | 2. DATE AND HOUR OF DEATH
<u>5/28/69</u> <u>2:20 PM</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>18-03</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNIVERSITY OF MARYLAND HOSPITAL</u>
<u>BALTIMORE MD 21201</u> | | | C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | E. STREET AND NUMBER
<u>125 PARKIN ST</u> | |
| 5. SEX
<u>M</u> | 6. RACE
<u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/6/69</u> | 9. AGE (In years last birthday)
<u>2</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>INFANT</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | 11. BIRTHPLACE (State or foreign country)
<u>BALTIMORE</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>ERNEST SHERMAN</u> | | | 14. MOTHER'S MAIDEN NAME
<u>DOROTHY TEAL</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>—</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | 17. INFORMANT
<u>Dorothy Teal</u> ADDRESS <u>125 Parkin St</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>HYPONIC BRAIN DAMAGE</u>
This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>SHOCK</u>
<u>SEPSIS - 20 E. COLI</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>60</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
<u>—</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>—</u> | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>—</u> | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)
<u>—</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR?
<u>—</u> | | 21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>—</u> | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>5/25/69</u> to <u>5/28/69</u> that (1) (we) last saw the deceased alive on <u>5/28/69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Robert I. Gingle</u> | | | 23B. DATE SIGNED
<u>5/28/69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>ROBERT I. GINGEL</u> | | | 23D. ADDRESS
<u>UNIVERSITY OF MARYLAND HOSP</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>5/31/69</u> | 24C. NAME of CEMETERY or CREMATORY
<u>McGowan Cem.</u> | 24D. LOCATION
<u>Balto.</u> | (City, town or county) (State)
<u>MD.</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, M.D.</u> | 25C. FUNERAL DIRECTOR
<u>Williams Funeral Home</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

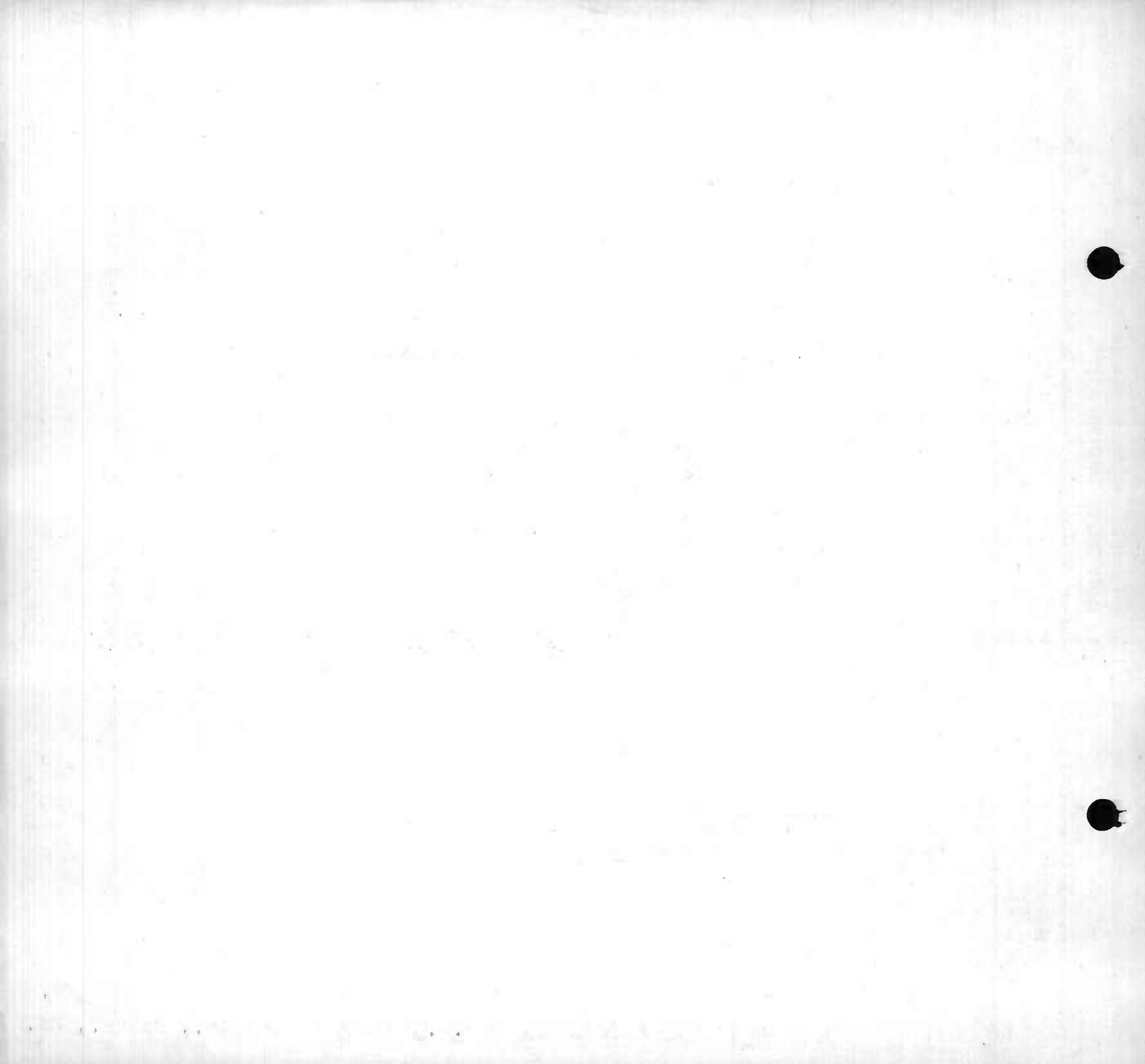
| BIRTH NO. 69 5604 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5604 | | | |
|---|--|---------------------------|--|---|--|---|--|--|---|--|--|
| 1. NAME OF DECEASED
(Type or Print) Mary A. Johnson | | | | | | 2. DATE AND HOUR OF DEATH
May 28, 1969 | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 19-01 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00340 N. Bruce St. | | | | | | C. CITY OR TOWN
Balto. | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | | E. STREET AND NUMBER
340 N. Bruce St. | | | | | |
| 5. SEX
Female | | 6. RACE
Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Jan. 10, 1900 | | 9. AGE (In years last birthday)
69 | | 10. Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME
James Spencer | | | | | | 14. MOTHER'S MAIDEN NAME
Anna Holland | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Perry Johnson 340 N. Bruce St. | | | | | |
| 18. 431.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Central Hemorrhage
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
Parkinson Syndrome | | | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Central Hemorrhage
(B) DUE TO, OR AS A CONSEQUENCE OF:
Parkinson Syndrome
(C) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-10-1969 to 5-28-1969 , that (I) (we) last saw the deceased alive on 5-28-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Richard H. Hunt | | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
5-29-69 | | |
| 23C. PHYSICIAN'S NAME (Type)
Richard H. Hunt | | | | | | 23D. ADDRESS
1607 W. Mulberry St. Balto. Md | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
5/31/69 | | 24C. NAME OF CEMETERY or CREMATORY
Western Star Cem. | | | 24D. LOCATION (City, town, or county) (State)
Catonsville Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | | 25B. NAME OF REGISTRAR
Richard E. Johnson, M.D. | | | | 25C. FUNERAL DIRECTOR
Williams Funeral Home 3199 N. Broadway St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print)
MEDORA W. ELLINGHAUS | | 2. DATE AND HOUR OF DEATH
5/24/69 at 1 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE BALTIMORE B. COUNTY 12-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE GOOD SAMARITAN HOSPITAL
5601 LOCH RAVEN BLVD
BALTIMORE, MARYLAND 21212 | | | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
312 SUFFOLK AVENUE BALTIMORE MD | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5/8/1890 | 9. AGE (In years last birthday)
79 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | | | | |
| 13. FATHER'S NAME
MORRIS WATKINS | | | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
25-30-2874 | |
| 17. INFORMANT
HOSPITAL RECORDS | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
GRAVE DISEASE CARCINOMA ATOSIS
DUE TO, OR AS A CONSEQUENCE OF:
CARCINOMA OF R. BREAST
DUE TO, OR AS A CONSEQUENCE OF:
11 years | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION lost.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Fracture of the right arm and a laceration of the right arm | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
gfrs | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/21/1969 to 5/27/1969 , that (I) (we) last saw the deceased alive on 5/27/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Caridad E. Gonzalez M.D. | | | | 23B. DATE SIGNED
5/27/69 | |
| 23C. PHYSICIAN'S NAME (Type)
CARIDAD E. GONZALEZ, M.D. | | | | 23D. ADDRESS
THE GOOD SAMARITAN HOSPITAL BALTO MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-31-69 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer | |
| 24D. LOCATION
Baltimore | | 24E. STATE
Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. J. [unclear] M.D. | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co., Balto., Md. | |



69 5606 CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

EMMA J. SMOTHERS

2. DATE AND HOUR OF DEATH

5/29/69

1 20 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE #212244. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2133 Druid Hill Avenue #21217

5. SEX

Female

6. RACE

Nergo

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9-4-84

9. AGE (in years
last birthday)

84

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Nurse

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Gilles

14. MOTHER'S MAIDEN NAME

Laura Tartar

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-16-3837

17. INFORMANT

Records: Baltimore City Hospitals

ADDRESS

4940 Eastern Avenue #21224

18.

195.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Cardio-Respiratory Arrest 10 min

(B) DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Thrombosis

4 yrs

(C) DUE TO, OR AS A CONSEQUENCE OF:

Pelvic Malignancy

1 1/2 yrs

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/13 19 68 to 5/29 19 69
that (I) (we) last saw the deceased alive on 5/29 19 69 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

V. Valdimanis, M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

5/29/69

23C. PHYSICIAN'S
NAME (Type)

V Valdimanis M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue

#21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-3-69

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

Ceadershill A.A. County Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Margaretta B. Brown 3106 Walbrook Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

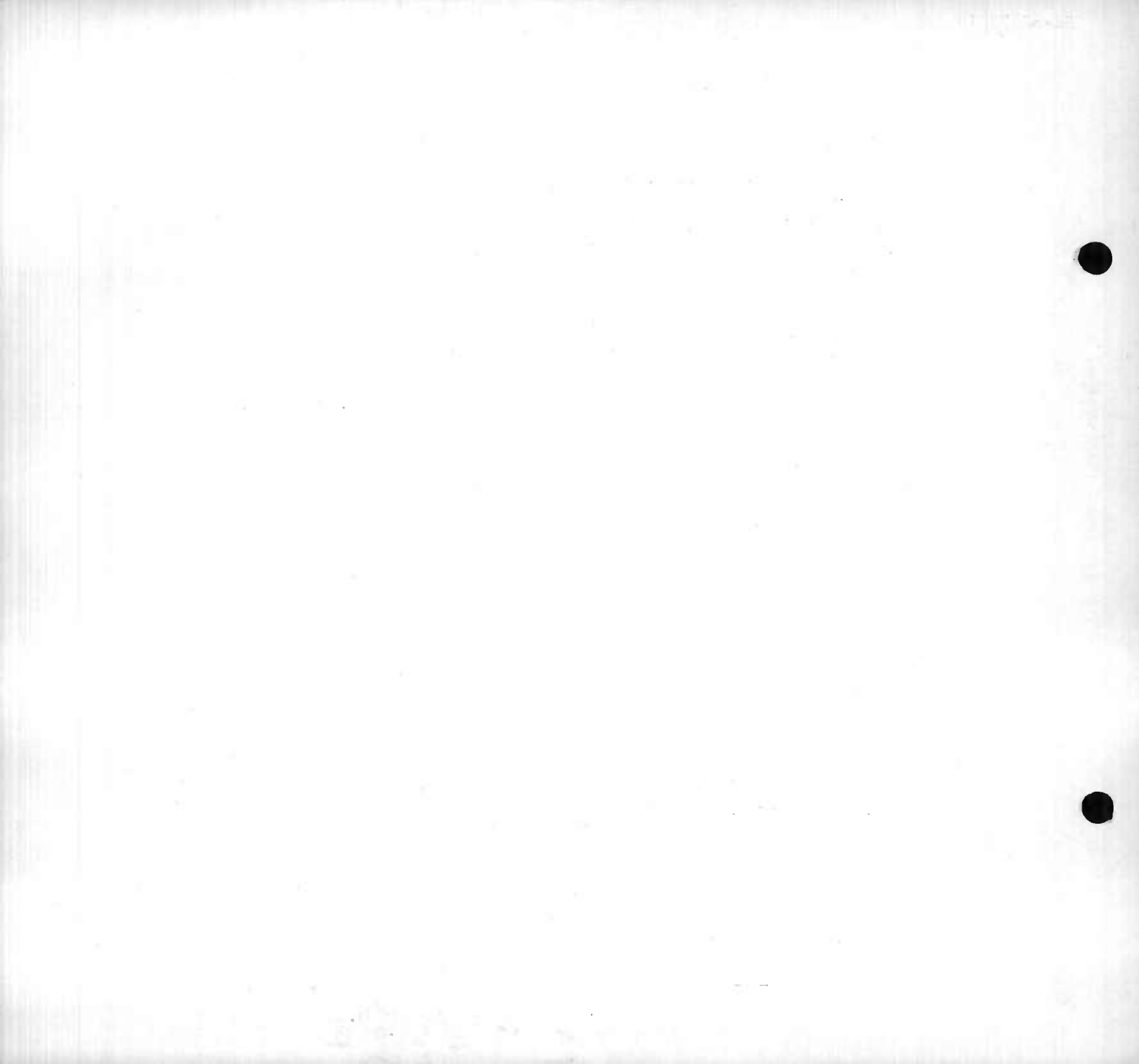
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|---|--------------------------------|--|---|
| 32-35-781 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5607 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Mary Kent</i> | | 2. DATE AND HOUR OF DEATH <i>5/31/69 11³⁰ P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) | | A. STATE <i>MARYLAND</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN <i>BALTIMORE</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| <i>31</i> <i>BALTIMORE CITY HOSPITALS</i>
<i>4940 EASTERN AVENUE</i>
<i>BALTIMORE, MARYLAND 21224</i> | | E. STREET AND NUMBER <i>931 S. SHARP STREET 21230</i> | | | |
| 5. SEX <i>FEMALE</i> | 6. RACE <i>NEGRO</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3-9-90</i> | 9. AGE (in years last birthday) <i>79</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | |
| 13. FATHER'S NAME <i>JOHN GROSS</i> | | 14. MOTHER'S MAIDEN NAME <i>MANDY</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD</i> | |
| 18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE <i>Uremia</i>
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (B) <i>Renal failure</i>
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) <i>ASCVD</i> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5/29 1969</i> to <i>5/31 1969</i> , that (I) (we) last saw the deceased alive on <i>5/31 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Dr. Case</i> | | 23B. DATE SIGNED <i>5/31/69</i> | | 23C. PHYSICIAN'S NAME (Type) <i>David B. Case, M.D.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>6-6-69</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Mt Calvary</i> | |
| 24D. LOCATION (City, town, or county) <i>A.A.Co.</i> | | 24E. ADDRESS <i>BCH-4940 EASTERN AVENUE, BALTIMORE, MD.</i> | | 25A. DATE REC'D BY HEALTH DEPT. | |
| 25B. NAME OF REGISTRAR <i>Isaiah L. Brown and Son</i> | | 25C. FUNERAL DIRECTOR <i>1005 W. Montgomery Street</i> | | 25D. ADDRESS | |

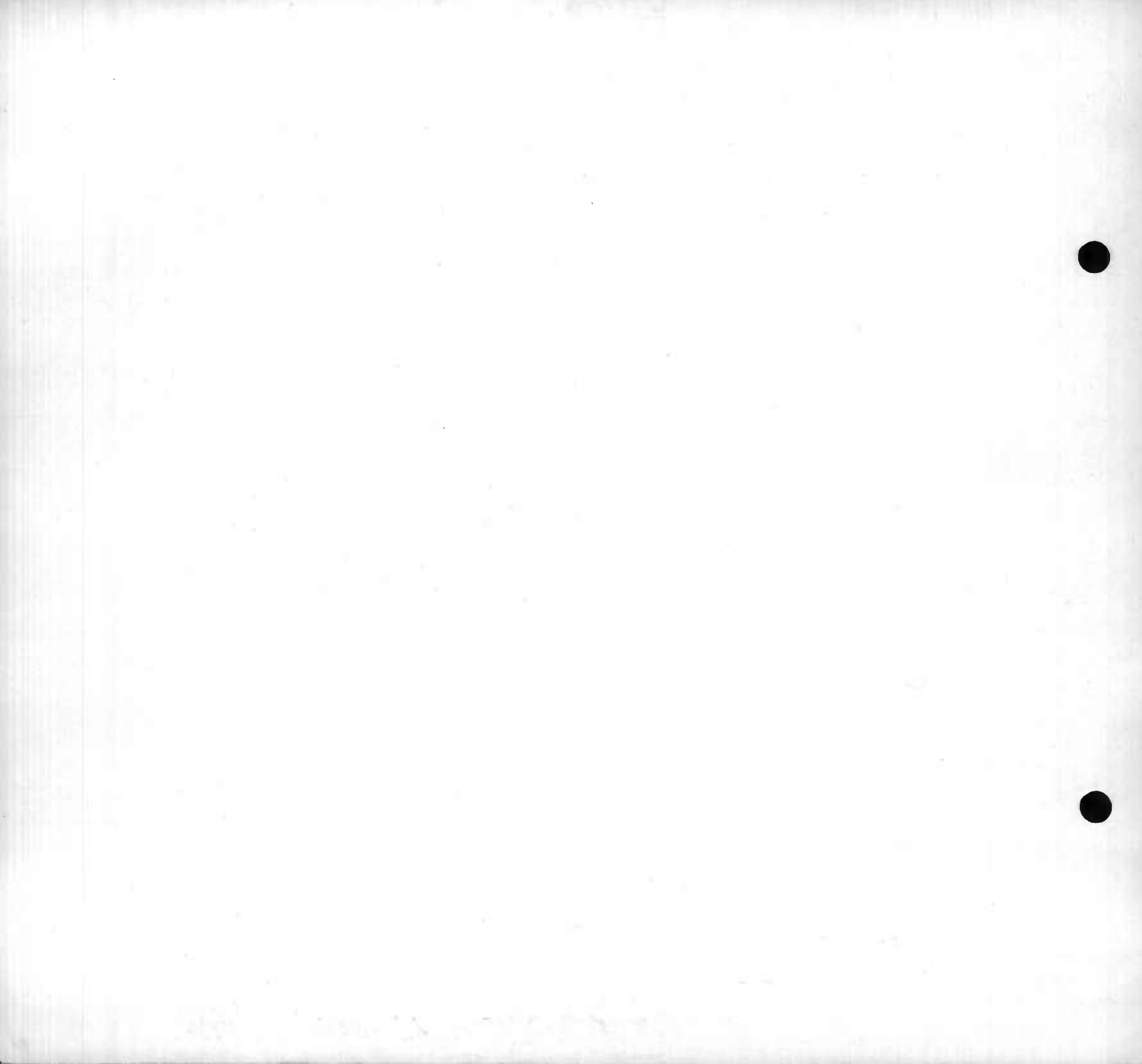


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Sara Davis | | 2. DATE AND HOUR OF DEATH
June 1 12:30 PM. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MD B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Harbor View Nursing Home
1213 Light St | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
151 W. Homburg St | | | | | |
| 5. SEX
F | 6. RACE
C | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1915 | 9. AGE (In years lost birthday)
54 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
unknown | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME
Edward German | | 14. MOTHER'S MAIDEN NAME
Maggie Casper | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 412.314250.9
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Septicemia, acute
(B) Diabetes Mellitus
(C) Old Myocardial Infarction - 6 months
(D) Arteriosclerosis Cordis Ventr
Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 hours | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from February 19 69 to May 31 19 69 , that (I) (we) lost saw the deceased alive on May 31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Rolando V. Goco | | | | 23B. DATE SIGNED
6-1-69 | |
| 23C. PHYSICIAN'S NAME (Type)
Rolando V. Goco, M.D. | | | | 23D. ADDRESS
707 E Fort Ave, Balt. 21230 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-5-69 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Auburn | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore City | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
James C. Gabe, MD | | 25C. FUNERAL DIRECTOR
539 Montgomery Street | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

NAME OF DECEASED
(Type or Print)

CAROLINE MELLERSON

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
5 30 69 4:58 p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

D.O.A.

South Balto. General Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour
May 30, 1969 4:58 p. M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

25-42

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

9/22/34

10. AGE (In years lost birth day)

34

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

2303 Round Rd.

11. BIRTHPLACE (State or foreign country)

Sumter S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Mellerson

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Nurse

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lucille Tolan

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Lucille Goodwin II 35 Sharp Street

19. E815.1

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Craniocerebral injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Frankfurt Ave. 1580'S. of 2nd St.

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

5 30 69 4:40p

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger in auto-fixed object coll.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Edward F. Wilson, MD.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 31, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)

Removal

24B. DATE

6-4-69

24C. NAME of CEMETERY or CREMATORY

Mt Zion

24D. LOCATION (City, town, or county) (State)

Summerton S.C.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

James E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Isaiah L. Brown and Son
108 W. Montgomery Street

ADDRESS

from mother
J. H. H. H.

1/20/11 34
J. H. H. H.

1/20/11

9

1/20/11 34

WALTON, EDWARD

WALTON, EDWARD

S-363

69 5610 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5610

BIRTH NO.

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED (P)
(Type or Print) IRENE T. STEWART | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> May 29, 1969
Hour 4:15 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
ST. AGNES HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
May 29, 1969
Hour 4:15 P. M. | |
| 6. SEX
Female | 7. RACE
White | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Balto. Co.
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH
4/15/97 | | 10. AGE (In years lost birthday) 72
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO.
218-09-9784 | |
| 18. INFORMANT
Mr. James Stewart, 4321 Allan Drive | | ADDRESS | |
| 19. CAUSE OF DEATH
412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
Arteriosclerotic cardiovascular disease
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
20A. DATE OF OPERATION
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
21. AUTOPSY? (Yes or No)
no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 5/30/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/2/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
George E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
Witzke, 4101 Edmondson Ave., 21229 | | ADDRESS | |

WALTON & CO.

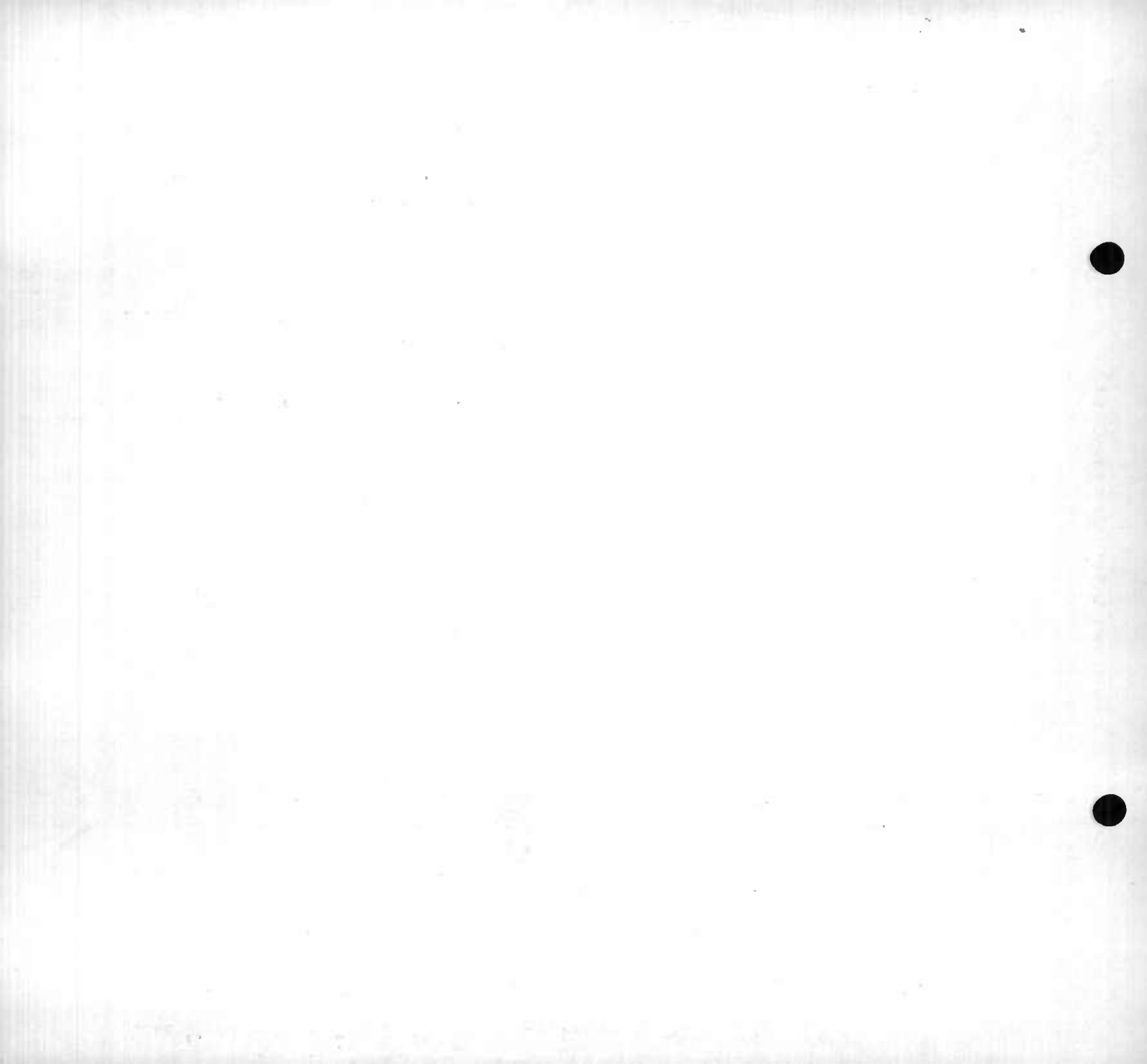
Handwritten signature or initials.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5611 | |
|--|--|---|---|--|---|
| BIRTH NO. 69 5611 | | 69 5611 CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Mrs. Nellie Jacobs</u> | | | 2. DATE AND HOUR OF DEATH
<u>5-31-69</u> <u>5:40 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>Hood Convalescent Home Inc.</u>
<u>5313 Edmondson Ave. Balto 29 Md.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>28-54</u> | | |
| 5. SEX <u>F</u> | | | 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
<u>Nov. 11, 1885</u> |
| 13. FATHER'S NAME
<u>Thomas Hudson</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Sarah</u> | | 9. AGE (In years lost birthday)
<u>84</u> |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country)
<u>England</u> |
| 17. INFORMANT
<u>Mrs. Margaret Lynch, 415 North Bend Road</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 18. <u>485 X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Respiratory arrest</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Branchopneumonia</u> | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>hours</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>Cerebro Vascular Insufficiency</u> | | | <u>months</u> | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/30</u> <u>June</u> <u>1969</u> to <u>5/31</u> <u>June</u> <u>1969</u> , that (I) (we) lost saw the deceased alive on <u>5/30</u> <u>June</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>James Nolan MD</u> | | | | 23B. DATE SIGNED
<u>5/31/69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>J J NOLAN</u> | | | | 23D. ADDRESS
<u>Baltimore Md 21229</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/2/69</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Western Cemetery</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | 25B. NAME OF REGISTRAR
<u>John E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Witzke, 4401 Edmondson Ave., 21229</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | ADDRESS
<u>4401 Edmondson Ave., 21229</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) CRAMER, MARY ADELINE | | | | 2. DATE AND HOUR OF DEATH
05-31-69 1:15 A.M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
ST. AGNES HOSPITAL
40 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE & COUNTY
MARYLAND BALTIMORE 21229 28-44 | | | | | | | |
| | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| | | | | E. STREET AND NUMBER
821 WICKLOW ROAD | | | | | | | |
| 5. SEX
FEMALE | | 6. RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-17-04 | | 9. AGE (In years last birthday)
64 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
CHARLES W. SUTER | | | | 14. MOTHER'S MAIDEN NAME
BERTHA BOWERS | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
218094820 | | 17. INFORMANT BALTIMORE, MD. 21229 ADDRESS
ST. AGNES HOSP. WILKENS & CATON AVENUES | | | | | |
| 18. 4319 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

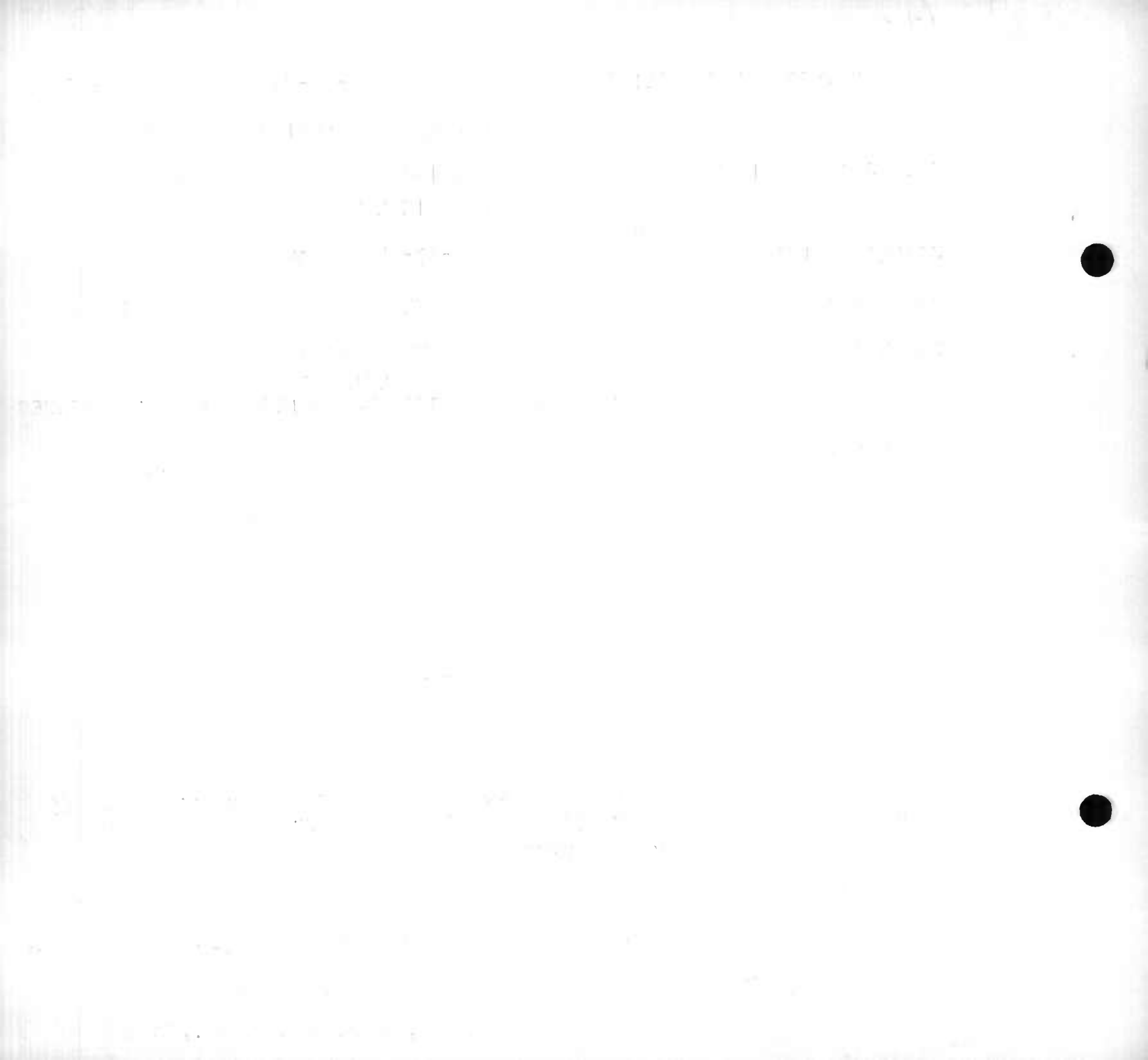
ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Cerebral Hemorrhage.

(B) arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF:

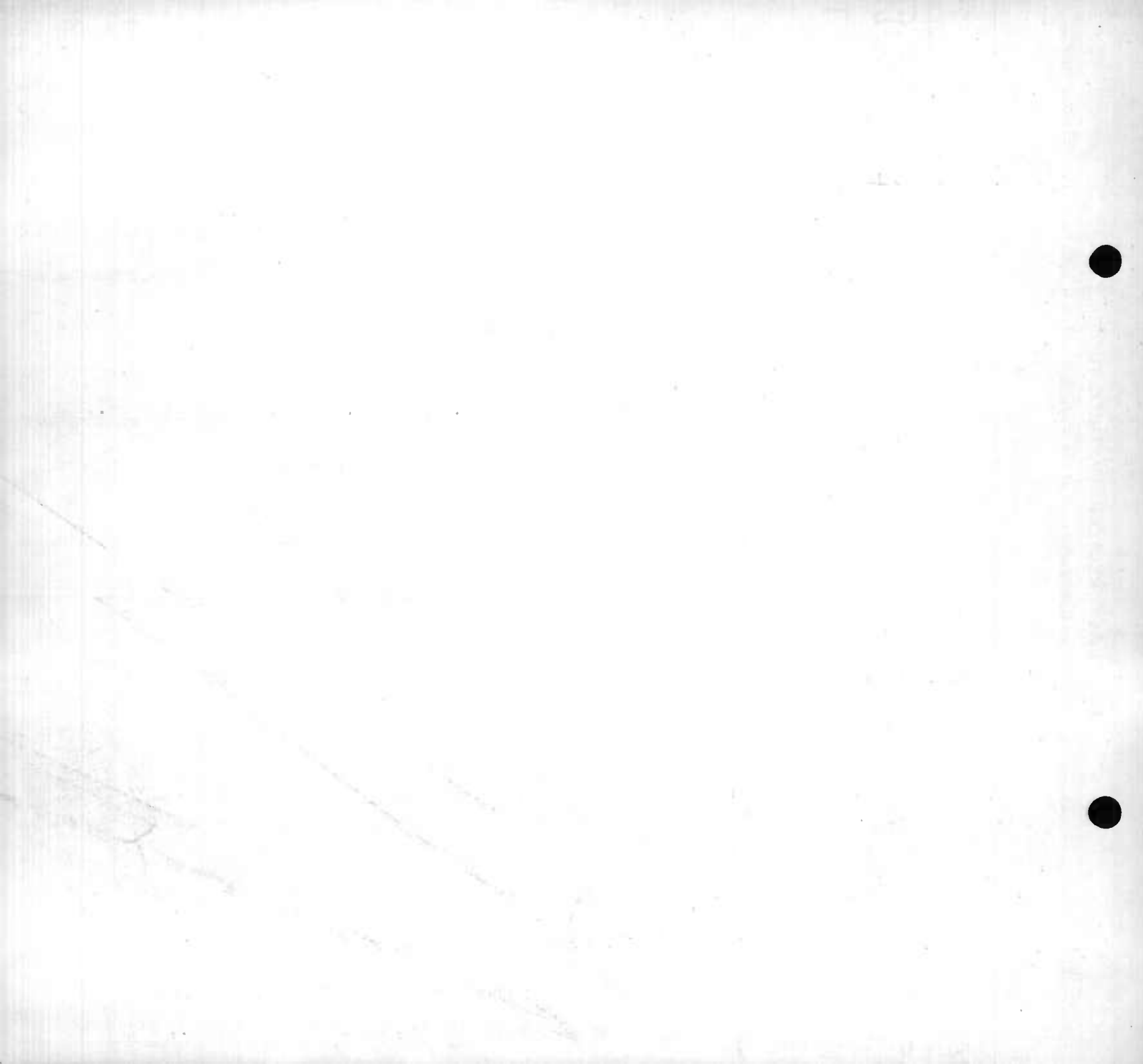
(C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | | | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from MAY 29 1969 to MAY 31 1969 that (X) (we) last saw the deceased alive on MAY 31 1969 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
M. D. [Signature] | | | | 23B. DATE SIGNED
5-31-69 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Muhammad Afzal M.D. | | | | 23D. ADDRESS
CATON & WILKENS AVES. - BALTO MD 21229 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/4/69 | | 24C. NAME of CEMETERY or CREMATORY
Meadowridge Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR
Witzke, 4001 Edmondson Ave., 21229 | | ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5613 | |
|---|--|---|--|--|--|
| BIRTH NO. 5-551 | | 69 5613 | | BALTIMORE CITY HEALTH DEPARTMENT | |
| 1. NAME OF DECEASED
(Type or Print)
MRS RAE SMINK | | | 2. DATE AND HOUR OF DEATH
6.1.69 12 45 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 16-06 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
34 BON SECOURS HOSPITAL | | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | E. STREET AND NUMBER 3023 HARLEM AVE | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/12/1899 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTO MD | |
| 13. FATHER'S NAME GEORGE W PHILLIPS | | 14. MOTHER'S MAIDEN NAME ? | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mr. Edward G. Denis, 3023 Harlem Ave., 21216 | |
| 18. 151.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Generalized carcinomas
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Ca of the stomach | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) ASCVD
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month | | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD | | | | | |
| 19A. DATE OF OPERATION 5.29.69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED pyloric obstruction | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5.17.69 19 to 6.1.69 19, that (I) (we) last saw the deceased alive on 5.31.69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert Ferrer | | | | 23B. DATE SIGNED 6.1.69 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERTO FERRER | | | | 23D. ADDRESS BON SECOURS HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 6/4/69 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. (State) | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR JUN 3 1969 Robert E. Harker, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave., 21229 | |



B-652

69 5614 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5614

BIRTH NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
MILTON BRINSON | | | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> May 29, 1969
Hour 8:25 P. M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
SINAI HOSPITAL | | | | 3. DATE PRONOUNCED DEAD
Month Day Year
May 29, 1969
Hour 8:25 P. M. | | | |
| 6. SEX
Male | | | | 7. RACE
Negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
Sept. 24, 1950 | | | | 10. AGE (In years lost birthday) 18 | | E. STREET AND NUMBER
3643 Cottage Avenue | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | | | 12. CITIZEN OF
U.S.A. | | 13. FATHER'S NAME | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
soldier | | | | 14B. KIND OF BUSINESS OR INDUSTRY
U.S. Army | | 15. MOTHER'S MAIDEN NAME | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes | | | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Mrs Carene Ford | |
| 19. 304.9
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Bronchopneumonia complicating intravenous narcotism | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
TOXIC SHOCK SYNDROME
(B) DUE TO, OR AS A CONSEQUENCE OF:
narcotism
(C) | | | |
| 20A. DATE OF OPERATION | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | | 22D. TIME OF INJURY (Approx.) | | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | 21. AUTOPSY? (Yes or No)
yes | | | |
| ACTUAL SIGNATURE
Ronald N. Kornblum
EXAMINER'S NAME (Type)
Ronald N. Kornblum, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
5/30/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
June 2, 1969 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Howard County Home of Harry Witzke | | ADDRESS
Ellicott City Maryland | |

Handwritten signature or mark.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5615 | |
|---|---------|--|------------------|--|-----------------------------|
| 69 5615 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | (WILLIAM) LANGSTON JACKSON | | June 1, 1969 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | | |
| 38 University Hospital | | Maryland | | | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 1005 Edmondson Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | 10. Under 1 Yr. Months Days |
| Male | Colored | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8-20-1909 | 59 | 11 Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Car Operator | | Baugh Chemical Co. | | Virginia | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Richard Jackson | | Susie Jackson | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 212-12-1220 | | Elizabeth Jackson - 1005 Edmondson Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE | | | |
| ANTECEDENT CAUSES | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-30-69 to 6-1-69 and that (I) (we) last saw the deceased alive on 5-19-69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| William H. Watts | | | | 5-2-69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| William H. Watts | | | | 515 N. Arlington St. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 6-4-69 | | Arbutus Memorial Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUN 3 1969 | | Robert E. Taylor, R.D. | | Charles E. Law 802 Madison Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5616 | |
|---|---------------|--|---|--|--|
| BIRTH NO. 5-420 | | 69 5616 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) HARRY SCHOLZ | | | 2. DATE AND HOUR OF DEATH 5/29/69 5:40 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 1940 EASTERN AVE. BALTIMORE, MD. 21224 | | | A. STATE MARYLAND BALTIMORE | | |
| | | | C. CITY OR TOWN 2nd Howard Ave | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | | E. STREET AND NUMBER #3 BAYSIDE AVE. 21052 005 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-20-85 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FACTORY | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND | |
| 13. FATHER'S NAME Lewis | | 14. MOTHER'S MAIDEN NAME ALSINDOLG | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 212-10-7755A | | 17. INFORMANT BCH RECORDS: 4940 EASTERN AVE. ADDRESS BALTIMORE, MARYLAND # 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 185X+1 250.9 | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-Respiratory Arrest 10 min | | |
| | | | (B) ASCVD w/ CHF DUE TO, OR AS A CONSEQUENCE OF: 2 yrs | | |
| | | | (C) Ca Prostate 3 yrs | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | DIABETES MELLITUS 10 yrs | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indefinite medical examined | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/17 19 69 to 5/29 19 69 that (I) (we) last saw the deceased alive on 5/29 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE V. Valdimanis, MD. | | | 23B. DATE SIGNED 5-29-69 | | |
| 23C. PHYSICIAN'S NAME (Type) V. VALDMANIS DR. | | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE, MARYLAND 21224 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 2/2/69 | | 24B. DATE 2/2/69 | | 24C. NAME OF CEMETERY OR CREMATORY Western Cem. | |
| 24D. LOCATION BALTO., MD. | | 24E. NAME OF REGISTRAR Robert E. J. J. J. | | 24F. FUNERAL DIRECTOR George H. Schwab Inc. 2101 FREDRICK | |
| 25A. DATE REC'D BY HEALTH DEPT JUN 3 1969 | | 25B. NAME OF REGISTRAR Robert E. J. J. J. | | 25C. FUNERAL DIRECTOR George H. Schwab Inc. 2101 FREDRICK | |

V. VALDMANIS DR.

4940 EASTERN AVE.

515-10-7752A BOH RECORDS; BALTIMORE, MARYLAND # 5152A
ALSIINDOIG
4940 EASTERN AVE.

FACTORY MARYLAND U.S.A.

site X

6-50-82 83

4940 EASTERN AVE. BALTIMORE, MD. 5152A #3 BAYSIDE AVE. 51025 002

X

MARYLAND BALTIMORE

FUNERAL DIRECTOR: IMPORTANT

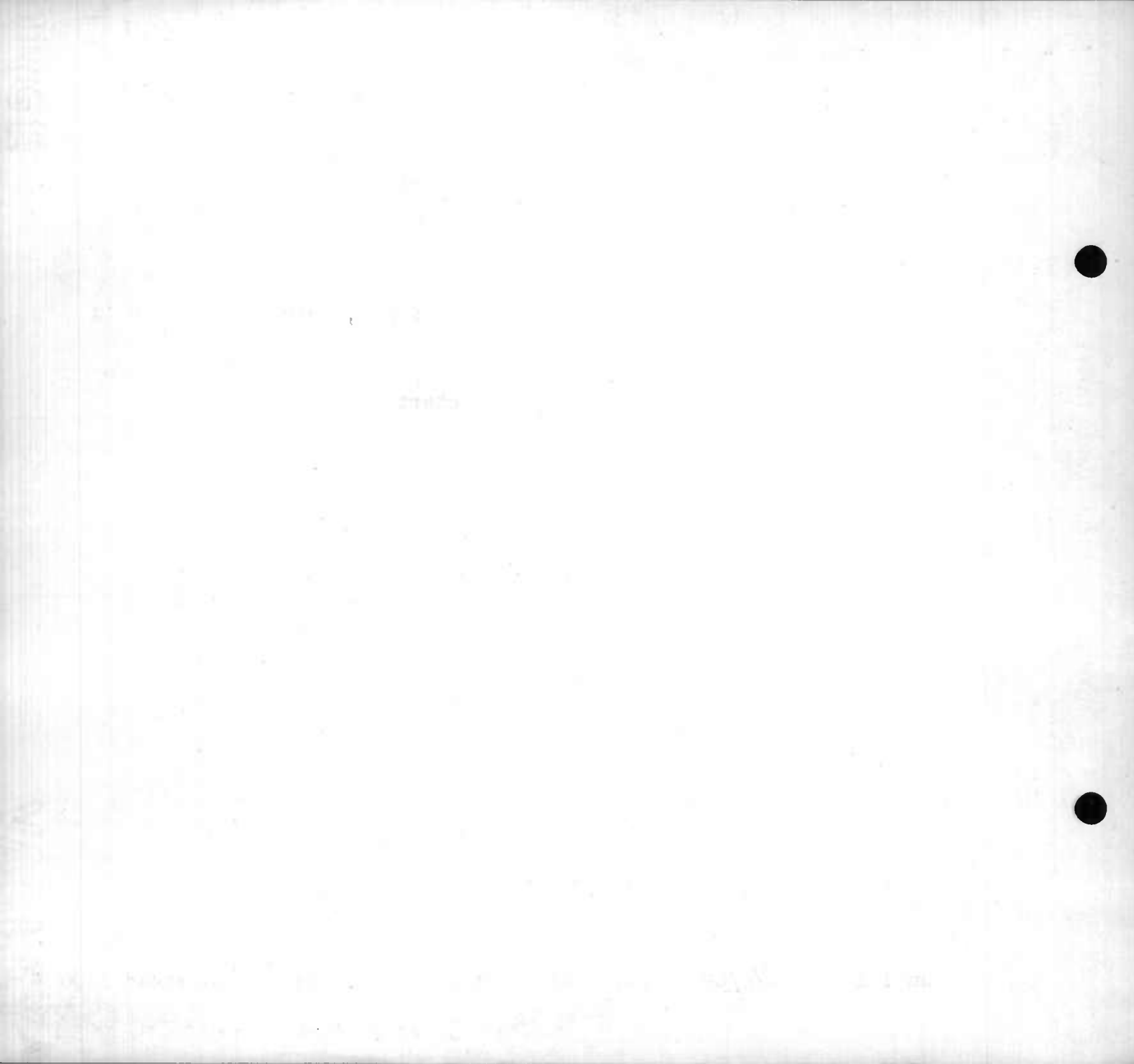
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. |
|--|--|--|--|----------|
| BIRTH NO. | | 69 5617 | | 69 5617 |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| WISEMAN, MARY # | | 5-31-69 4:10 PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | |
| 44 UNION mem. Hosp | | M.D. Balto. 53-00 | | |
| 5. SEX | | 6. RACE | | |
| F | | W | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | |
| WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10-9-79 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9. AGE (In years last birthday) | | |
| NONE | | 89 | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | |
| NONE | | MARYLAND | | |
| 13. FATHER'S NAME | | 12. CITIZEN OF WHAT COUNTRY | | |
| THOMAS KELLEY | | U.S. | | |
| 14. MOTHER'S MAIDEN NAME | | 17. INFORMANT | | |
| ALICE DONNELLEY | | DAUGHTER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | |
| No | | 213-48-3664 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | 19. CAUSE OF DEATH | | |
| II | | Res p. failure | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause: (A) slowing the UNDERLYING CONDITION last. | | DUE TO, OR AS A CONSEQUENCE OF: | | |
| severe arteriosclerosis, emphysema | | (B) renal failure, heart failure | | |
| | | DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | fx. hips | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | 20A. AUTOPSY? (Yes or No) | | |
| NONE | | No | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| <input checked="" type="checkbox"/> | | None | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| 8013 Belair Rd 53-00 | | 5-14-69 | | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | |
| While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | fell while going to B.R. | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-14-69 to 5-31-69 | | | | |
| that (I) (we) last saw the deceased alive on A.M. 5-31-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | |
| Brennenido B. Capati M.D. | | 5-31-69 | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | |
| Brennenido B-CAPATI | | U M H | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | |
| Burial | | 6-4-69 | | |
| 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | |
| Holy Redeemer Cemetery | | Baltimore Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | |
| JUN 3 1969 | | Robert E. Jaber, M.D. | | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | |
| Lippell Bros Inc. | | 7110 Belair Road | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>1908 5618</u> |
|--|--|---|--|---|
| BIRTH NO. <u>69 5618</u> | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>SPANN, WILLIAM</u> | | 2. DATE AND HOUR OF DEATH
<u>8:12 am 6/1/69</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if in institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Harbor View Training Center</u>
<u>1212 1st St. Md</u> | | A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX <u>male</u> 6. RACE <u>white</u> | | E. STREET AND NUMBER <u>2821 W. Mulberry St</u> | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Age 77</u> 9. AGE (In years last birthday) <u>76</u> | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u> | | 11. BIRTHPLACE (State or foreign country) <u>Obion, Tenn</u> | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>?</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | |
| 13. FATHER'S NAME <u>?</u> | | 14. MOTHER'S MAIDEN NAME <u>?</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>chart</u> |
| 18. <u>185 X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypercalcemia</u>
(B) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF:
(C) <u>with Bone metastases</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>months</u>
<u>2 yrs</u> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/10/69</u> to <u>6/1/69</u> that <u>He</u> last saw the deceased alive on <u>6/1/69</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>A. C. Alevisatos</u> | | 23B. DATE SIGNED <u>6/1/69</u> | | 23C. PHYSICIAN'S NAME (Type) <u>A. C. ALEVISATOS, M.D.</u> |
| 23D. ADDRESS <u>1209 SA Paul St Baltimore Md 21202</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>6/6/69</u> | | |
| 24C. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u> | | 24D. LOCATION <u>Baltimore</u> (City, town, or county) (State) | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1969</u> | | 25B. NAME OF REGISTRAR <u>Adolphus Halstead</u> | | |
| 25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u> | | ADDRESS <u>1206 W North Ave</u> | | |



m-520

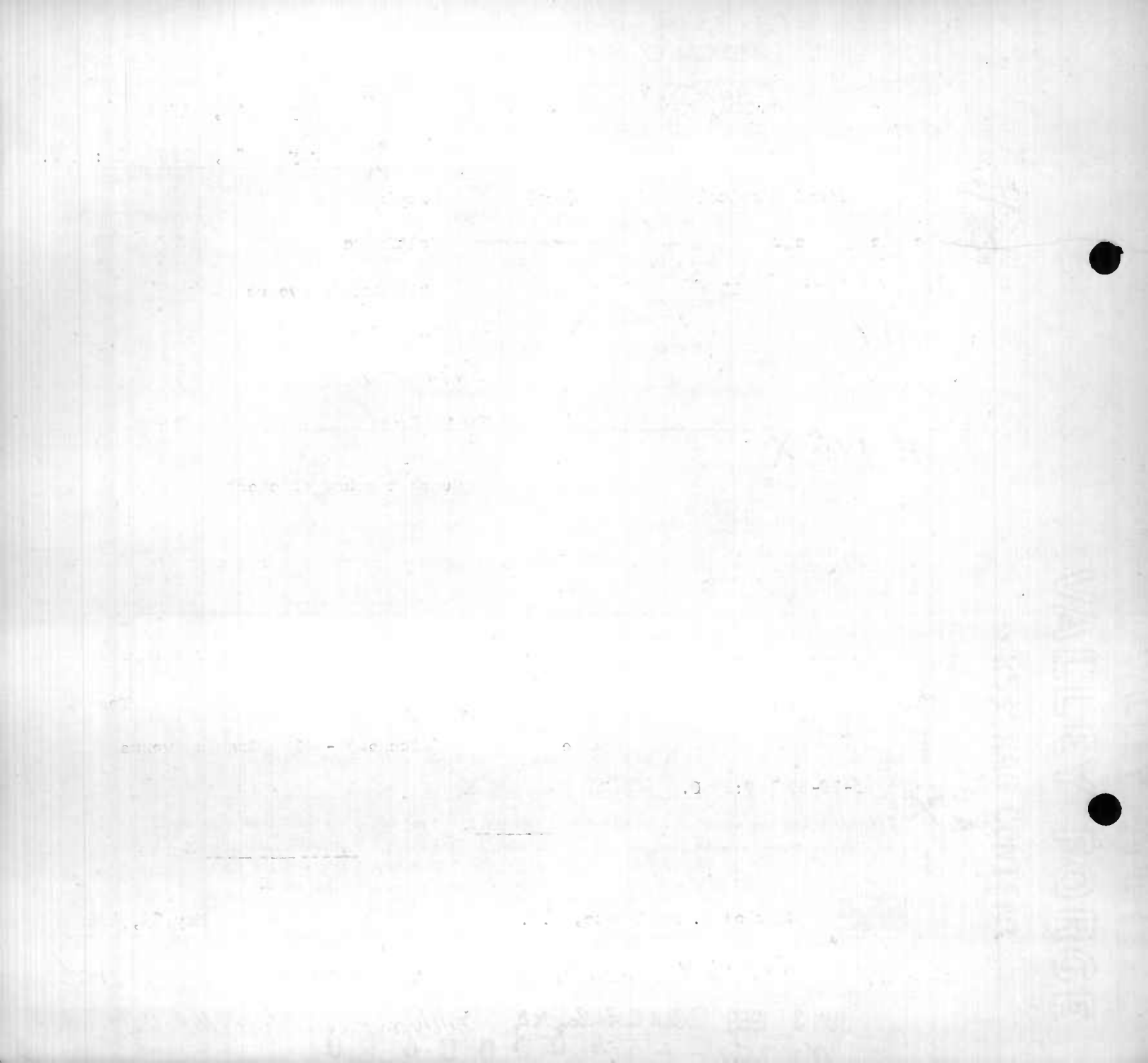
69 5619 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5619
REG. NO.

BIRTH NO.

| | | | | |
|---|-------------------------|---|--|--|
| 1. NAME OF DECEASED
(Type or Print)
ANDERSON
GLENDA MUNGO | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year
May 28, 1969 | | Hour
10:41 P.M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
Sinai Hospital (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
May 28, 1969 | | Hour
10:41 P.M. |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 15-10 | | | | |
| 6. SEX
Female | 7. RACE
Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore |
| 9. DATE OF BIRTH
Dec. 13, 1946 | | 10. AGE (In years lost birthday)
22 | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country)
Md | | 12. CITIZEN OF WHAT COUNTRY? | | E. STREET AND NUMBER
4209 Granda Avenue |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | | 13. FATHER'S NAME
Allen Anderson |
| 15. MOTHER'S MAIDEN NAME
Sula Haines | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service) | | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Husband | | |
| 19. CAUSE OF DEATH
E 9851 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
Yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
home | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
(Kitchen) - 4209 Granda Avenue |
| 22D. TIME OF INJURY (APPROX.)
5-28-69 9:30 P.M. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
? |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | |
| ACTUAL SIGNATURE
Charles S. Springate
EXAMINER'S NAME (Type) | | M.D.
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
May 29, 1969 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-4-69 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Mem. PK. |
| 24D. LOCATION (City, town, or county) (State)
Arbutus Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | |
| 25B. NAME OF REGISTRAR
Robert E. Zuber, M.D. | | 25C. FUNERAL DIRECTOR
1011-13 Sullivan Funeral Home - N. Arlington Ave | | |

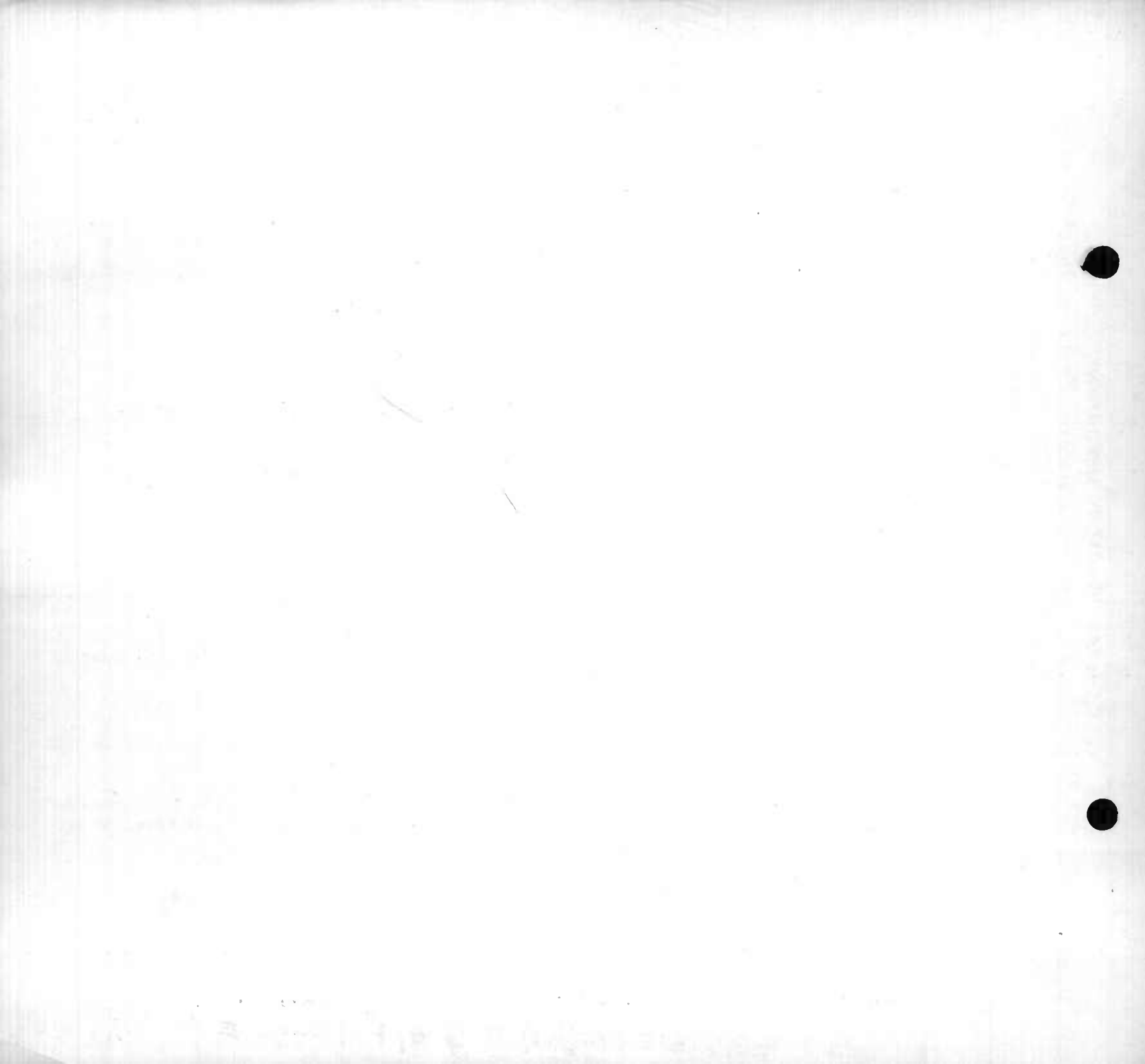


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 69 5620 |
|--|--|--|---|---|---------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Lena Rogers | | May 27 1969 410 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

00 1604 Mountmor Court
Baltimore, Maryland | | | A. STATE
Maryland
B. COUNTY
Baltimore
C. CITY OR TOWN
Baltimore
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX
F | | 6. RACE
Col. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
June 16, 1902
9. AGE (In years last birthday)
66 | |
| 11. BIRTHPLACE (State or foreign country)
Almac Co. Va. | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME
Lenord Northern | | | 14. MOTHER'S MAIDEN NAME
Ida Ross | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
215 18 4867 | | 17. INFORMANT
Murice Northern 1640 Mountmor Ct. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
Interosclerotic Cardiovascular Disease
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 yrs | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Feb 21 19 69 to April 12 19 69, that (1) (we) lost saw the deceased alive on April 12 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A. C. Alevizatos, M.D.
DEGREE | | | | 23B. DATE SIGNED
May 29, 1969 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| A. C. Alevizatos, M.D. | | | | 1209 St. Paul Street Baltimore, Md. 21202 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | May 31/69 | | Mt. Auburn | |
| 24D. LOCATION (City, town, or county) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| Balto., Md. | | JUN 3 1969 | | Robert E. Talbot, M.D. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 3 1969 | | Robert E. Talbot, M.D. | | Joseph Y. Run | |
| 25D. ADDRESS
2222 W. North Ave | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67-13023

REG. NO. _____

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
MICHELLE HAZEL | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
5 31 69 1:15 p. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
Sinai Hospital D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 31, 1969 1:15 p. M. | |
| 6. SEX
Female | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 15-11 | |
| 7. RACE
Colored | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
July 4, 1967 | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years lost birthday)
1 1/2 | | E. STREET AND NUMBER
3627 Columbus Dr. | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Larry Cuttingham | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Child | |
| 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME
Barbara Hazel | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 17. SOCIAL SECURITY NO.
-0- | |
| 18. INFORMANT
Mrs. Barbara Powell | | ADDRESS
1208 Jefferson Ct. | |
| 19. CAUSE OF DEATH
E 8147
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (A) IMMEDIATE CAUSE Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
YES | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
<input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
Columbus Dr. S. at Ridgewood Rd. | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)
5 31 69 1:00 p | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Subject pedestrian | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE Edward F. Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>

DATE SIGNED June 1, 1969 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-3-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | | ADDRESS
1701 Laurens St. | |

46

1875/1876

WALL

1875/1876

ST. JAMES

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
JOHN D. HARLEY | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
5 30 69 10:54 a. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
Franklin Square Hospital D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 30, 1969 10:54 a.m. | |
| 6. SEX
Male | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE
Colored | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
2-23-1923 | | 10. AGE (In years lost birthday)
46 | |
| 11. BIRTHPLACE (State or foreign country)
Dillon Co., S.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY
Harbison-Walker | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 17. SOCIAL SECURITY NO.
250-20-6773 | |
| 15. MOTHER'S MAIDEN NAME
Mary Alford | | 18. INFORMANT
Mrs. Francis Harley | |
| 19. CAUSE OF DEATH
410.9
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Fatty alteration of the liver | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No)
YES | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED May 31, 1969 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-5-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
New Zion Ch. Cem. | | 24D. LOCATION (City, town, or county) (State)
Dillon Co., S.C. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | | ADDRESS
1701 Laurens St. | |

1/14

1.114

WILLIAMS

VALLEY PARK

25/11/1914

1.114

FUNERAL DIRECTOR: IMPORTANT

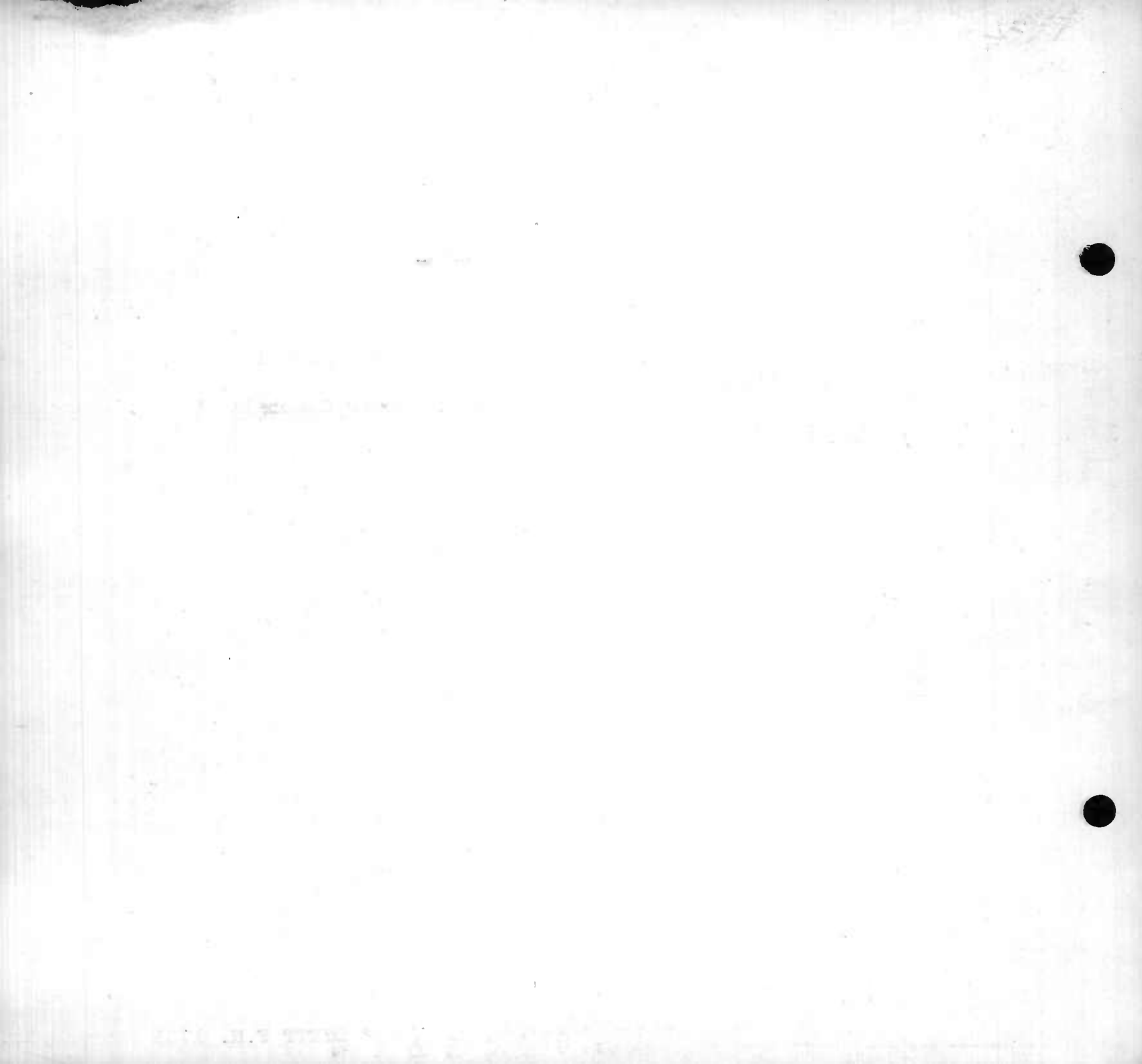
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 69 5623 | | 1. NAME OF DECEASED (Type or Print) STREET, Sarah | | 2. DATE AND HOUR OF DEATH 69 5623 May 30, 1969 5:00 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 17-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland | | C. CITY OR TOWN Baltimore | |
| 90 Bolton Hill Nursing & Convalescent Ctr. | | B. COUNTY | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 641 West Franklin Street | | 5. SEX F | | 6. RACE Negro | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-15-1910 | | 9. AGE (In years lost birthday) 58 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 13. FATHER'S NAME William X Campbell | | 14. MOTHER'S MAIDEN NAME X (Sophie Campbell) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. 039-12-9309 | | 17. INFORMANT ADDRESS Mr. Thomas Campbell 641 W. Franklin | |
| 18. I 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cancer of colon | | months | |
| ANTECEDENT CAUSES | | (B) Hemiplegia right | | months | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) atherosclerosis generalized | | years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/12 1969 to 5/30 1969, that (I) (we) last saw the deceased alive on 5/30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Allan H. Macht | | 23B. DATE SIGNED 5/30/69 | | 23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT M.D. | |
| 23D. ADDRESS 2 E Reed St Baltimore 21202 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 6-5-69 | |
| 24C. NAME OF CEMETERY OR CREMATORY Balto. Nat. Mortuary | | 24D. LOCATION (City, town, or county) Balto., Md. | | 25A. DATE RECORDED BY HEALTH DEPT. JUN 3 1969 | |
| 25B. NAME OF REGISTRAR Robert E. Fisher, R.D. | | 25C. FUNERAL DIRECTOR MORTON & DWETT F.H. | | ADDRESS 1701 Laurens St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5624 |
|---|---|---|--|---|
| BIRTH NO. 69 5624 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Saunders Berkley | | 2. DATE AND HOUR OF DEATH
6/1/69 1:45 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE md. B. COUNTY 16-07 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
46 Lutheran Hosp. of Md. | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
Balto. |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
3135 Water St. | | |
| 5. SEX
M | 6. RACE
N. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-3-19 | 9. AGE (In years last birthday)
50 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Burner | | 10B. KIND OF BUSINESS OR INDUSTRY
Boston Metal Co. | | 11. BIRTHPLACE (State of foreign country)
Ringgold Virginia |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
John Henry Saunders | | |
| 14. MOTHER'S MAIDEN NAME
Melissa GUNN | | 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)
No. | | |
| 16. SOCIAL SECURITY NO.
229-16-7079 | | 17. INFORMANT
Mrs. Julia H. Saunders | | |
| 18. 450 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute Pulmonary embolism | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/31/69 to 6/1/69 that (I) (we) last saw the deceased alive on 6/1/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Hyung Kyoun Park M.D. | | 23B. DATE SIGNED
6/1 | | 23C. PHYSICIAN'S NAME (Type)
Hyung Kyoun Park M.D. |
| 23D. ADDRESS
730 Ashburton St. Balto. 21216 | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | |
| 24B. DATE
6-4-69 | | 24C. NAME OF CEMETERY or CREMATORY
Saunders Family Cem. | | 24D. LOCATION (City, town, or county) (State)
Ringgold Virginia |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Morton & Dyett Funeral Home |



5-514

69 5625 BALTIMORE CITY HEALTH DEPARTMENT

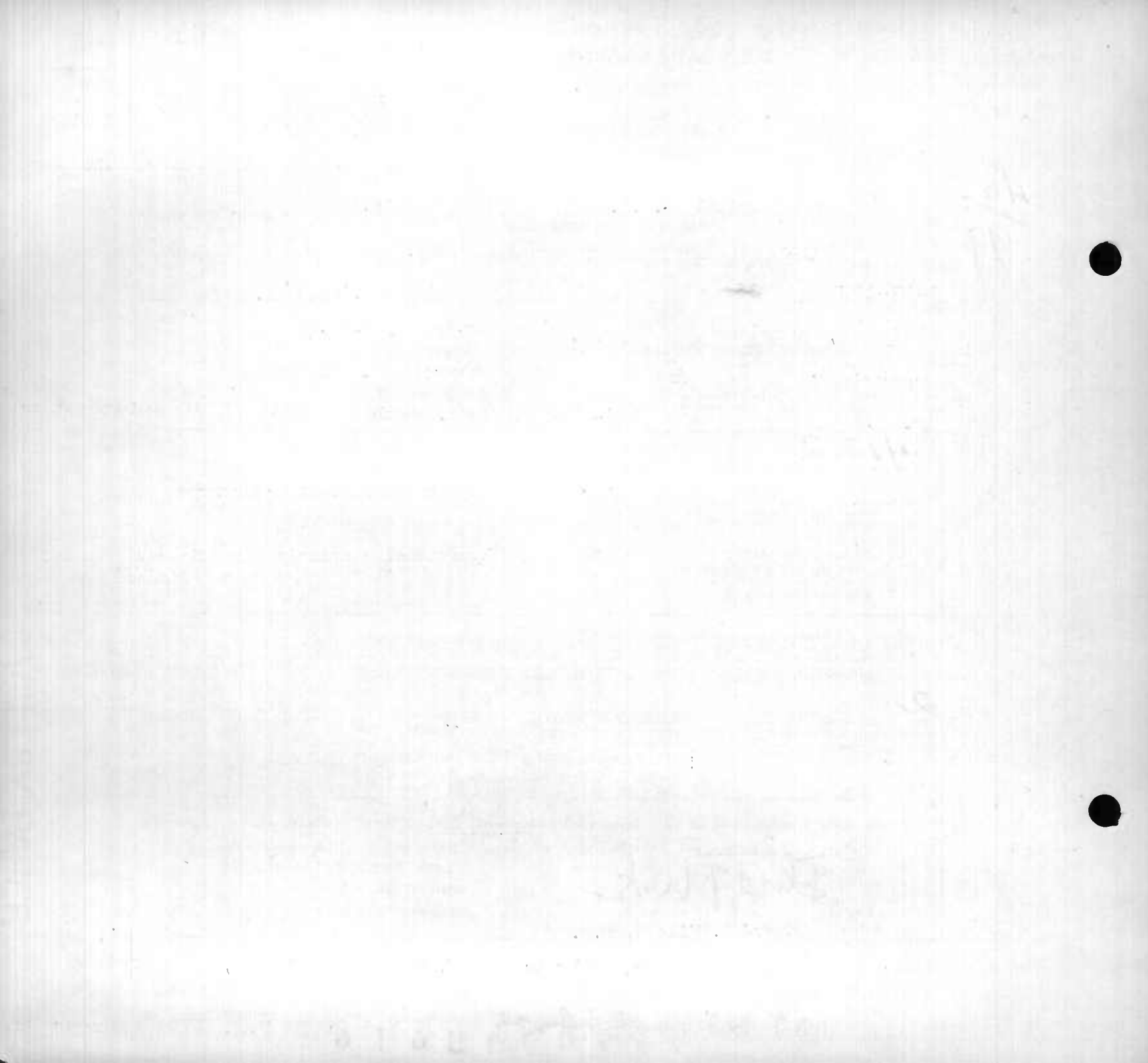
69 5625

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

| | | | |
|---|--|---|---|
| 1. NAME OF DECEASED
(Type or Print)
JAMES L SAMPLES | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
6 1 69 12:01 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
Lutheran Hospital D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 1 1969 12:01 a.m. | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 16-08 | |
| 6. SEX
Male | 7. RACE
Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
6-17-1932 | | 10. AGE (In years lost birthday) 36 | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Supervisor | | 14B. KIND OF BUSINESS OR INDUSTRY
Zoo | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 17. SOCIAL SECURITY NO.
220-24-1049 | |
| 18. INFORMANT
Mrs. Esther Sample | | ADDRESS
2810 Reisterstown Rd. | |
| 19. 412.2
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Spontaneous brain hemorrhage | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
hypertensive arteriosclerotic cardiovascular disease | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No)
YES | |
| 23.
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED June 1, 1969 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
6-5-69 | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cemetery | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | 25B. NAME OF REGISTRAR
Robert E. Faber, M.D. | 25C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | ADDRESS
1701 Laurens St. |



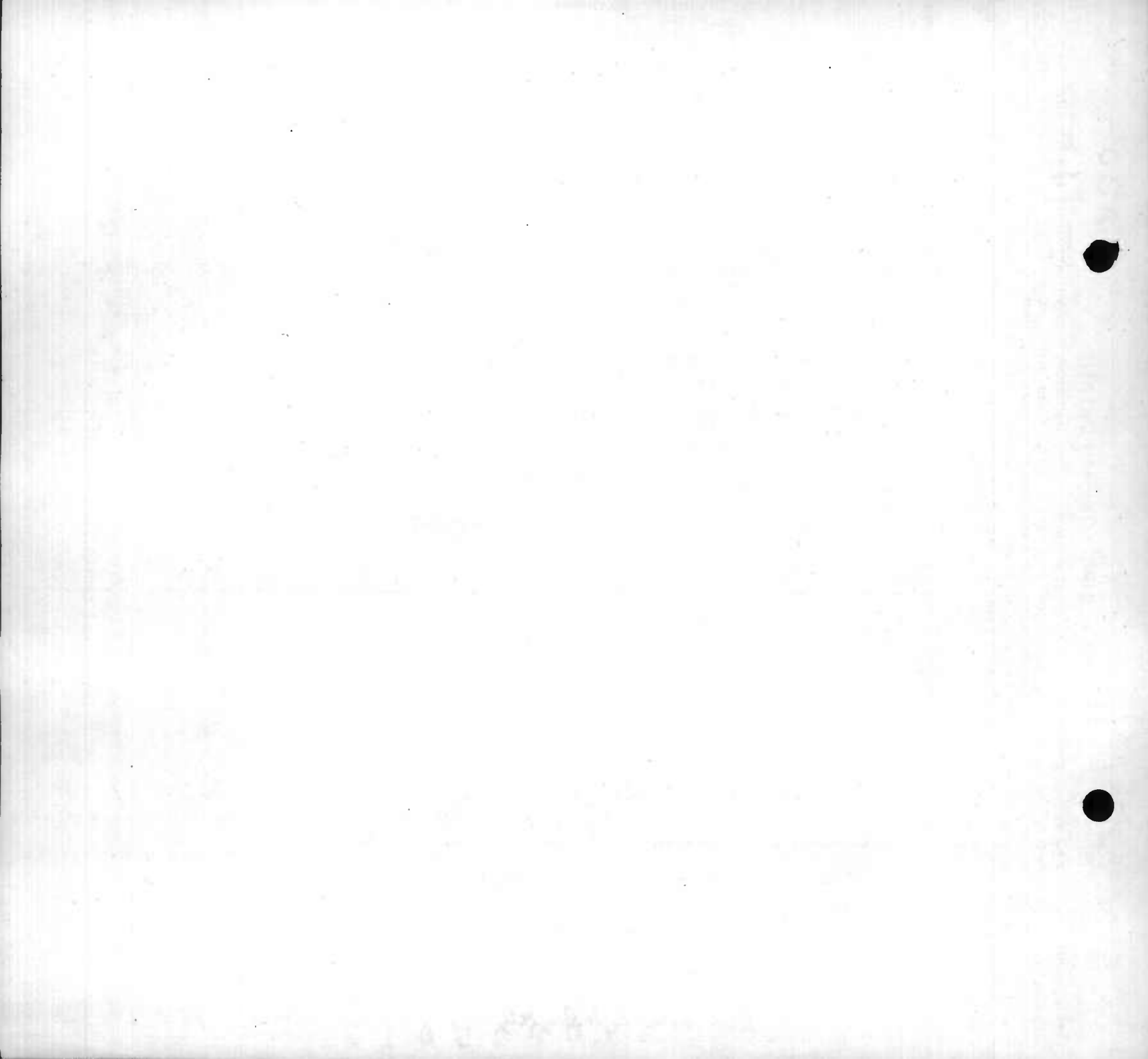
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5626 | |
|--|---|---|--|---|---|
| BIRTH NO. | | 69 5626 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) ESTELLE TALBOTT | | 2. DATE AND HOUR OF DEATH
5/31/69 11:45 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
90 LINCOLN NURSING HOME | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 15-47 | | | |
| | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
33-4 ELGIN AVENUE | | | |
| 5. SEX
F | 6. RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/13/97 | 9. AGE (In years last birthday)
72 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Johnsville, Maryland | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Alexander Rheubottom | | 14. MOTHER'S MAIDEN NAME
Emma B. Rheubottom | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mr. Franklin Talbott Same | |
| 18. 250.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

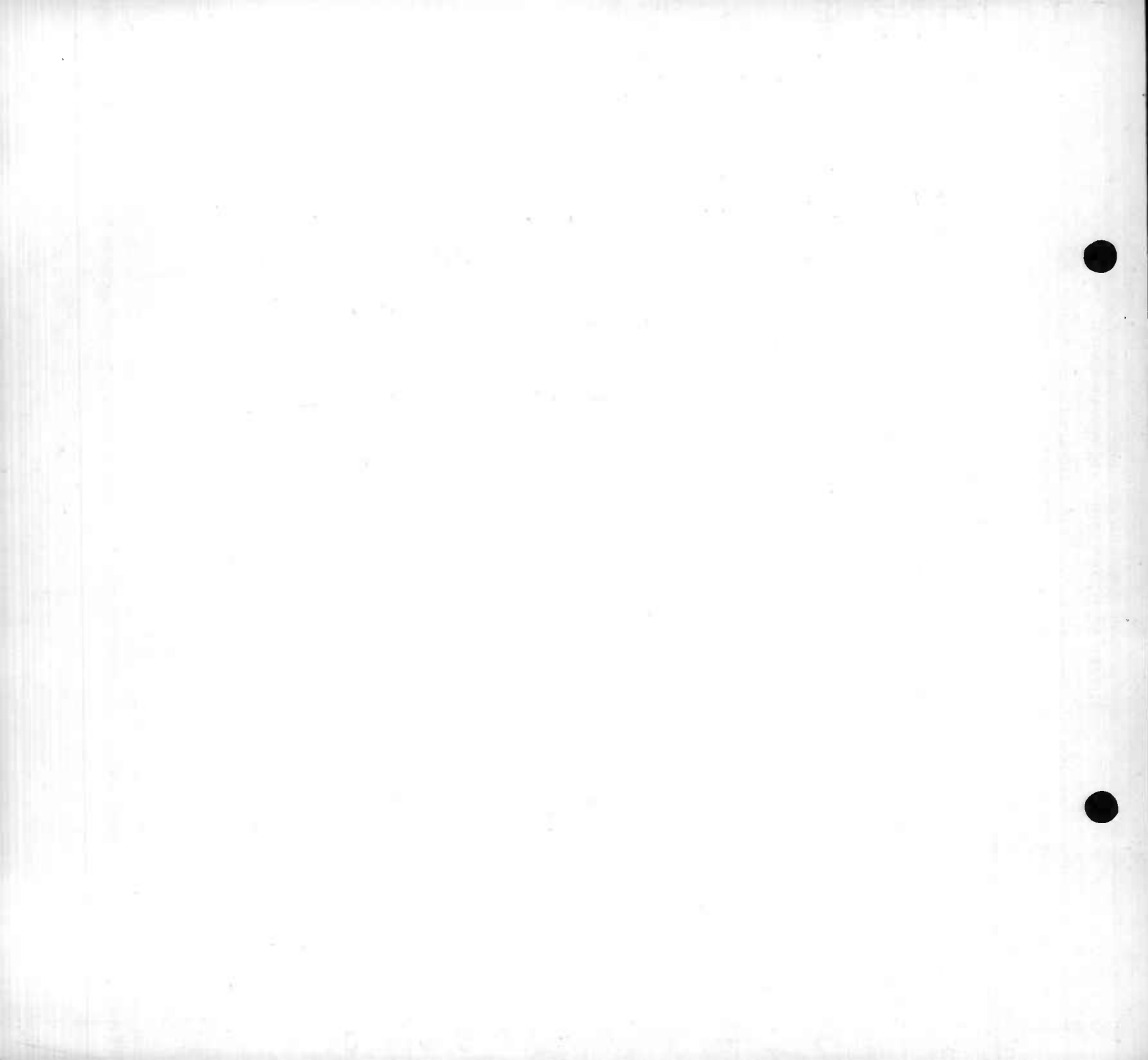
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
CEREBRAL THROMBOSIS
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
CEREBRAL ARTERIOSCLEROSIS
(B) DUE TO, OR AS A CONSEQUENCE OF:
DIABETES MELLITUS
(C) _____ | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/17/69 19 to 5/31/69 19, that (I) (we) last saw the deceased alive on 5/31/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Hollis Seunarine | | 23B. DATE SIGNED
5/31/69 | | 23C. PHYSICIAN'S NAME (Type)
HOLLIS SEUNARINE | |
| 23D. ADDRESS
1801 GREENBELLY RD MD | | 23E. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | |
| 23F. NAME OF REGISTRAR
Robert E. Talbot, M.D. | | 23G. FUNERAL DIRECTOR
Horton & Dyett F.H. | | 23H. ADDRESS
1701 Laurens St | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-5-69 | | 24C. NAME OF CEMETERY or CREMATORY
Johnsville Ch. Cem. | |
| 24D. LOCATION (City, town, or county)
Carroll Co., Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5627 | |
|--|----------------------|---|-------------------------------------|---|---|
| BIRTH NO. 236 | | 69 5627 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) FOSTER, Albert | | 2. DATE AND HOUR OF DEATH May 31, 1969 5:05 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
31 Baltimore City Hospital
4940 Eastern Ave Baltimore, Md. | | A. STATE Maryland | | B. COUNTY Baltimore | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER
107 Cypress Ct. #21222 | | | |
| 5. SEX M | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-1-1899 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland, Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Dent (Dennis Foster) | | 14. MOTHER'S MAIDEN NAME
Fronie Foster | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
213-09-4263 | | 17. INFORMANT ADDRESS
BCH Records: 4940 Eastern Ave
Baltimore, Maryland #21224 | |
| 18. 431.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
Aspiration pneumonia
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Intra-cranial hemorrhage | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
1 day | | (B) DUE TO, OR AS A CONSEQUENCE OF:
2 days | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
5/30/69 69 to 5/31 69 | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/31 19 69 to 5/31 19 69 , that (I) (we) last saw the deceased alive on 5/31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Jose Torres | | 23B. DATE SIGNED
5-31-69 | | | |
| 23C. PHYSICIAN'S NAME (Type)
JOSE TORRES MD. | | 23D. ADDRESS
Baltimore City Hospital
4940 Eastern Ave Baltimore, Maryland #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-4-69 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Mem. Park | |
| 24D. LOCATION
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
MORTON & DYETT F.H. 1701 Laurens St. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5628

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) GEORGE SLEDGE | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> May 30, 1969 1:19 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1027 N. Calhoun Street | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 30, 1969 1:19 A.M. | |
| 6. SEX
Male | | 7. RACE
Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 16-02 | |
| 9. DATE OF BIRTH
6-16-1912 | | 10. AGE (In years lost birthday) 56 | |
| 11. BIRTHPLACE (State or foreign country)
Weldon, North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME
Lessie Miller | | 13. FATHER'S NAME
George R. Sledge, Sr. | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes. | | 17. SOCIAL SECURITY NO.
218-03-5459 | |
| 18. INFORMANT
Mrs. Plumma Sledge | | ADDRESS
1027 N. Calhoun St | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
E880X
Fracture Neck | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
1027 N. Calhoun Street | | 22F. HOW DID INJURY OCCUR?
Subject fell down steps | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)
May 30, 1969 1:00 A.M. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Edward F. Wilson
EXAMINER'S NAME (Type) Edward F. Wilson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-4-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Baltimore Nat'l Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | | ADDRESS
1701 Laurens St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) A physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5629 | |
|---|---------------------|---|---|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Marie Lawson</u> | | 2. DATE AND HOUR OF DEATH
<u>6/2/69</u> <u>18:30</u> <u>A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>University Hospital</u>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE
<u>Md</u> | | B. COUNTY
<u>18-01</u> |
| | | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER
<u>906 W. Fairmont</u> | | | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>3-1-23</u> | 9. AGE (in years last birthday)
<u>46</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>H.W.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | |
| 13. FATHER'S NAME
<u>— Lessie Jenkins</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Issac Jenkins</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>Husband</u> ADDRESS
<u>Same</u> | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE
<u>Tentorial Herniation</u>
DUE TO, OR AS A CONSEQUENCE OF: | | | | <u>2 hrs</u> | |
| (B) <u>Intracerebral Hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF: | | | | <u>16 hrs</u> | |
| (C) <u>Hypertension</u> | | | | <u>11 years</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>—</u> | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLINO OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)
<u>—</u> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
<u>—</u> | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>—</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> 19 <u>69</u> to <u>June 2</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>June 2</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Martin Schwartz</u> | | | | 23B. DATE SIGNED
<u>June 2 1969</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Martin Schwartz</u> | | | | 23D. ADDRESS
<u>Univ Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6-6-69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Mt. Auburn Cem.</u> | |
| 24D. LOCATION
<u>Baltimore, Md</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Morgan E. Dyett F.H.</u> | | | |
| 25D. ADDRESS
<u>1201 Laurens St</u> | | | | | |



Released & approved by Medical Examiner, Dr. Hoffman, 5/27/69

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5630 CERTIFICATE OF DEATH

REG. NO. 69 5630

| | | | | | |
|--|--------------|---|------------------------------|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) IRENE COLLINS | | 2. DATE AND HOUR OF DEATH
5/27/69 11:10 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY
Baltimore Maryland 12-03 | | C. CITY OR TOWN
Balto | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNION MEMORIAL HOSPITAL
44 | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
2402 N. Calvert Street | |
| 5. SEX
F | 6. RACE
N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
9/20, 22 | 9. AGE (in years last birthday)
46 yr. | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
domestic | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
N. Carolina | |
| 13. FATHER'S NAME
John McLaughlin | | 14. MOTHER'S MAIDEN NAME
Liddie Evans | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Opemetta Mitchell | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
410.9 + 1250.9 | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Ac mi
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF:
Probable Diabetic mellitus | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2d ? | |
| MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
II
19A. DATE OF OPERATION
0 | | | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/26 1969 to 5/27 1969 that (I) (we) last saw the deceased alive on 5/27 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Charles S. Brown, M.D. | | | | 23B. DATE SIGNED
5/27/69 | |
| 23C. PHYSICIAN'S NAME (Type)
CHARLES S. BROWN M.D. | | | | 23D. ADDRESS
UNION MEMORIAL HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
5/30/69 | | 24C. NAME OF CEMETERY or CREMATORY
Lillingston Star | |
| 24D. LOCATION
Lillingston | | 24E. LOCATION
(City, town, or county)
N.C. | | 24F. LOCATION
(State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
J. E. Fahn, M.D. | | 25C. FUNERAL DIRECTOR
William Phillips | |
| 25D. ADDRESS
1727 N. Monmouth St. | | 25E. ADDRESS | | 25F. ADDRESS | |



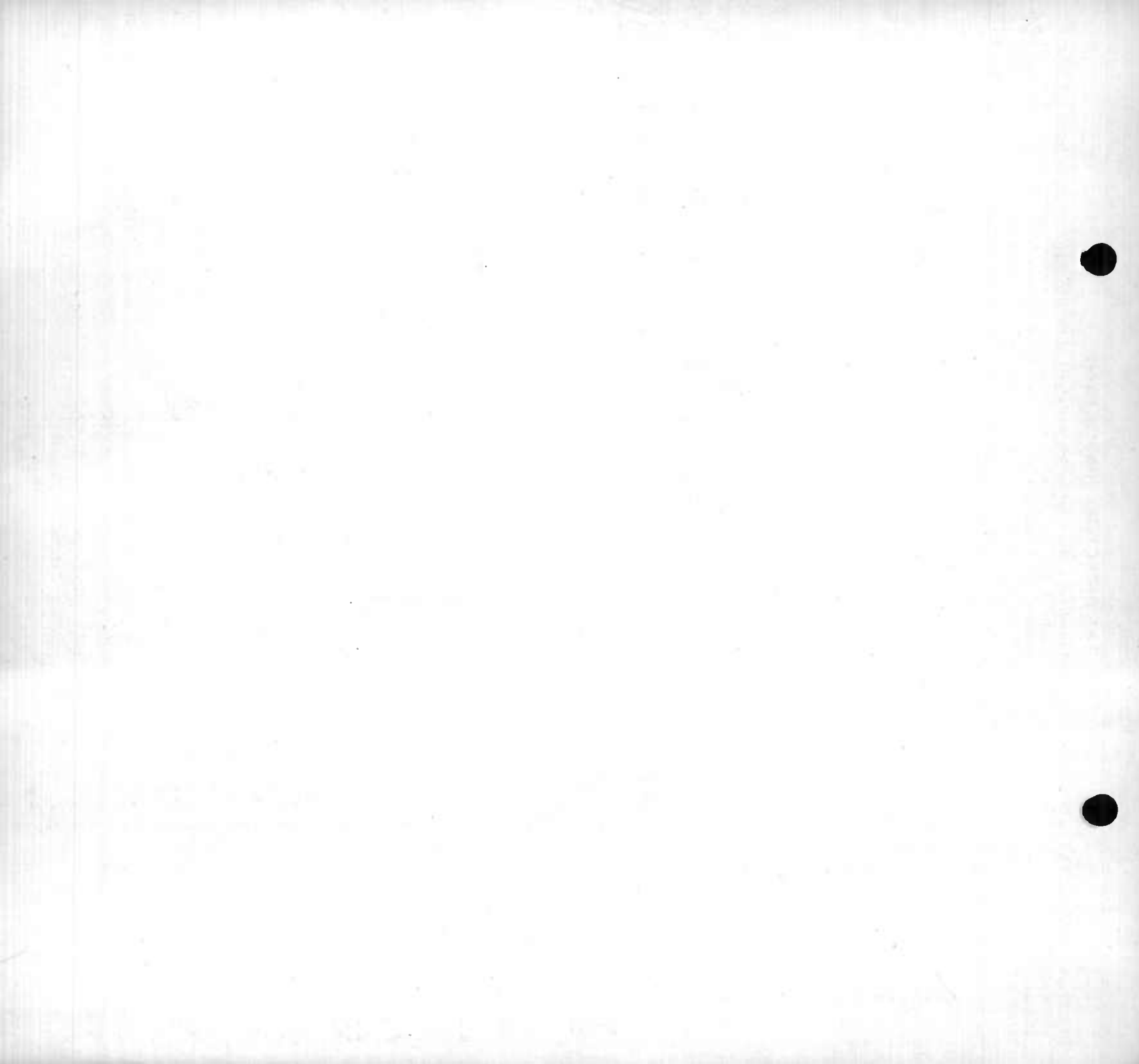
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5631 CERTIFICATE OF DEATH

REG. NO. 69 5631

| | | | | | |
|---|--------------|---|--|---|---------------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Dorothea E. Lee | | 5/31/69 2:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Jewish Congregation Home
4601 Ball Mall Rd | | | | A. STATE
MD | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | B. COUNTY
14-03 | |
| | | | | C. CITY OR TOWN
Baltimore | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
2313 Division St | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb 11-1926 | 9. AGE (In years last birthday)
43 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 13. FATHER'S NAME
Samuel Taylor | | 14. MOTHER'S MAIDEN NAME
Hallie Ford | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Robert E. Lee - 2313 Division St | |
| 18. I | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or compulsion which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
BRAIN STEM HERNIATION | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) BRAIN TUMOR | | 8 years. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) BRAIN STEM HERNIATION
Hashimoto's thyroiditis | | 1 year. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/30 1968 to 5/31 1969, that (I) (we) last saw the deceased alive on 5/31 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
M.F. SAIONTZ, M.D. | | | | 23B. DATE SIGNED
5/31/69 | |
| 23C. PHYSICIAN'S NAME (Type)
M.F. SAIONTZ, M.D. | | | | 23D. ADDRESS
4000 W. Northern Pkwy | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-3-69 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Mem PK | |
| 24D. LOCATION
Baltimore | | 24E. LOCATION (City, town, or county)
Baltimore | | 24F. LOCATION (State)
MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
John E. Phillips | | 25C. FUNERAL DIRECTOR
John E. Phillips | |
| | | | | ADDRESS
1727 W. 4th St. | |



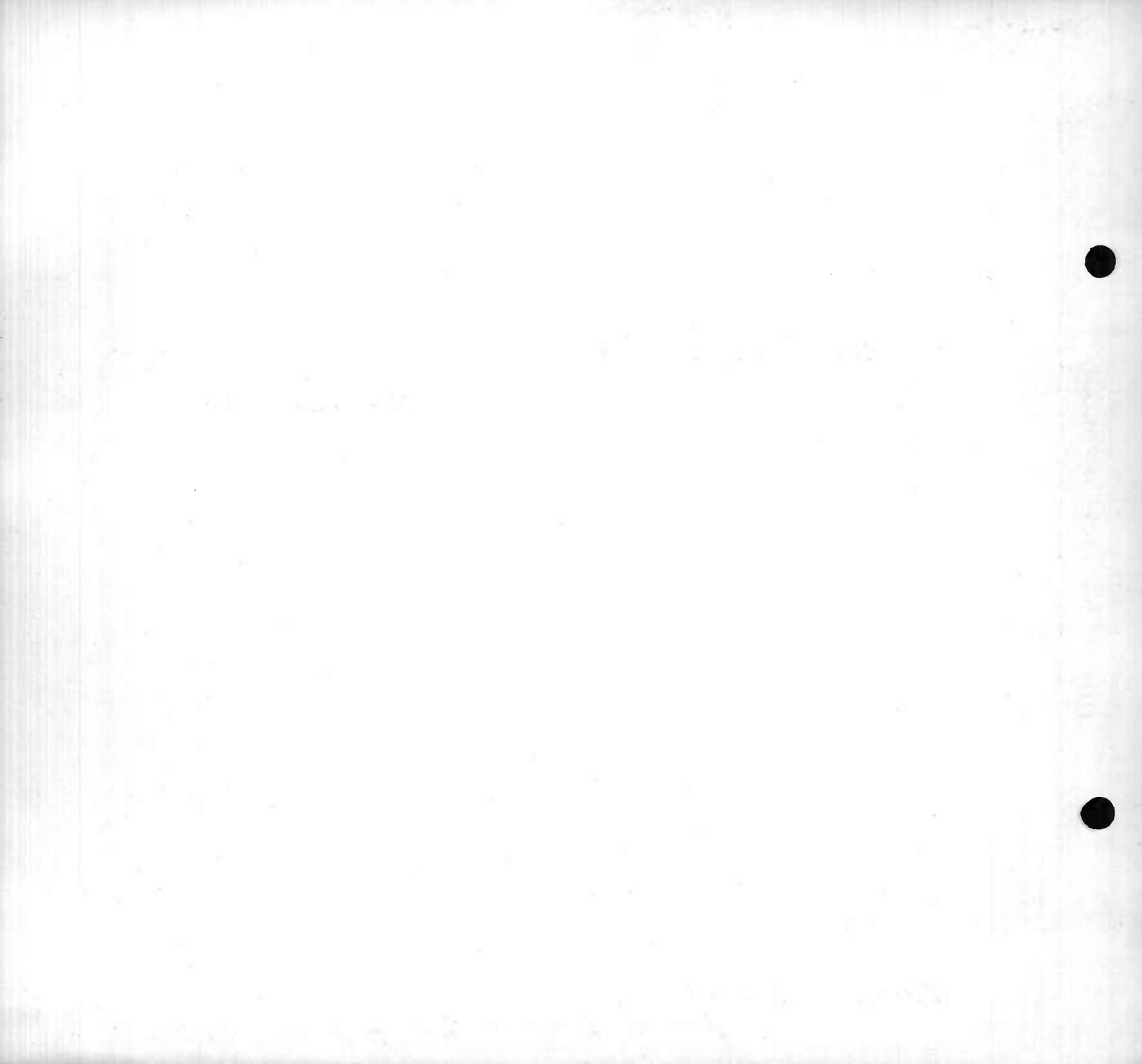
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5632 | |
|--|---------------------|--|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) TIMOTHY J. DICKERSON | | 2. DATE AND HOUR OF DEATH
MAY 30/69 6:30 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
LUTHERAN HOSPITAL
46 BALTIMORE, MD. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY 15-04 | | |
| | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
1917 WALBROOK AVE. | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 29/10 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
SOUTH CAROLINA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Matthews Dickerson | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Ann Dickerson | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

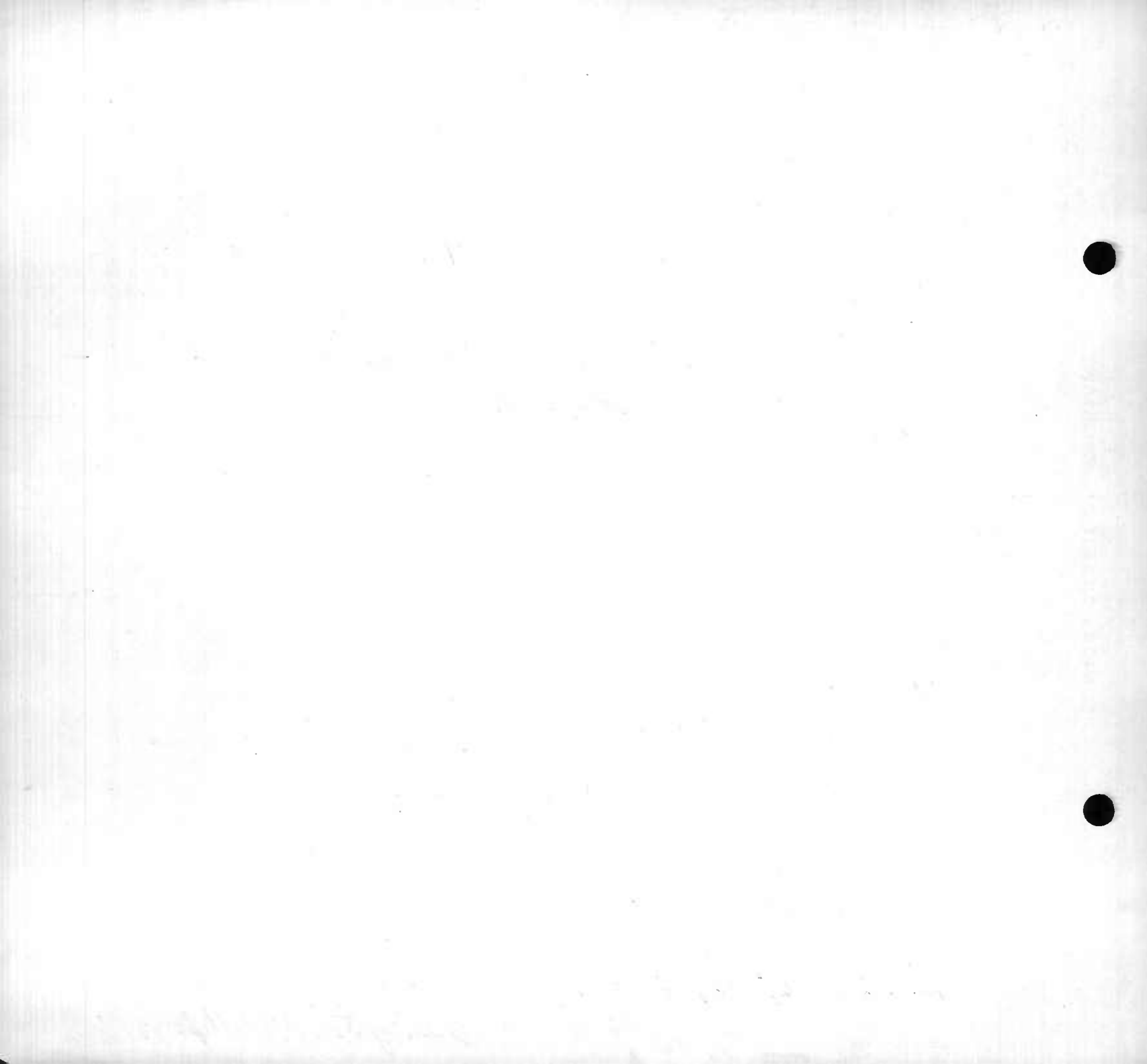
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
ACUTE MYOCARDIAL INFARCTION
(B) CORONARY HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 30 19 69 to MAY 30 19 69 , that (I) (we) last saw the deceased alive on MAY 30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dionisio Garcia Jr. | | | | 23B. DATE SIGNED
5/30/69 | |
| 23C. PHYSICIAN'S NAME (Type)
DIONISIO GARCIA JR. | | | | 23D. ADDRESS
LUTHERAN HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-3-69 | | 24C. NAME OF CEMETERY or CREMATORY
St. Calvary | |
| 24D. LOCATION
Baltimore, MD | | 24E. FUNERAL DIRECTOR
Phillips-12277 Moore | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
James E. Hall | | 25C. ADDRESS
Baltimore | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5633 | |
|---|-----------|--|--------------------------|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Robert Mitchell | | 2. DATE AND HOUR OF DEATH 5/29/69 7:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 15-11 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER 3508 Liberty Heights Ave. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/18/02 | 9. AGE (In years last birthday) 66 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William Mitchell | | 14. MOTHER'S MAIDEN NAME Mary M.V. unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. 115-14-0469 | | 17. INFORMANT Marcella Mitchell (wife) ADDRESS same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction | | less than 5 minutes | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Arteriosclerotic Heart disease | | DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) | | unknown duration | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 6 none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1965 to 5/29 1969 that (I) (we) last saw the deceased alive on 5/29 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE D.W. Stewart, M.D. | | 23B. DATE SIGNED 5/29/69 | | 23C. PHYSICIAN'S NAME (Type) D.W. STEWART | |
| 23D. ADDRESS 2300 Garrison Blvd. | | 23E. DEGREE | | 23F. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 6/2/69 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. LOCATION (City, town, or county) Md. | | 24F. LOCATION (City, town, or county) | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 3 1969 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

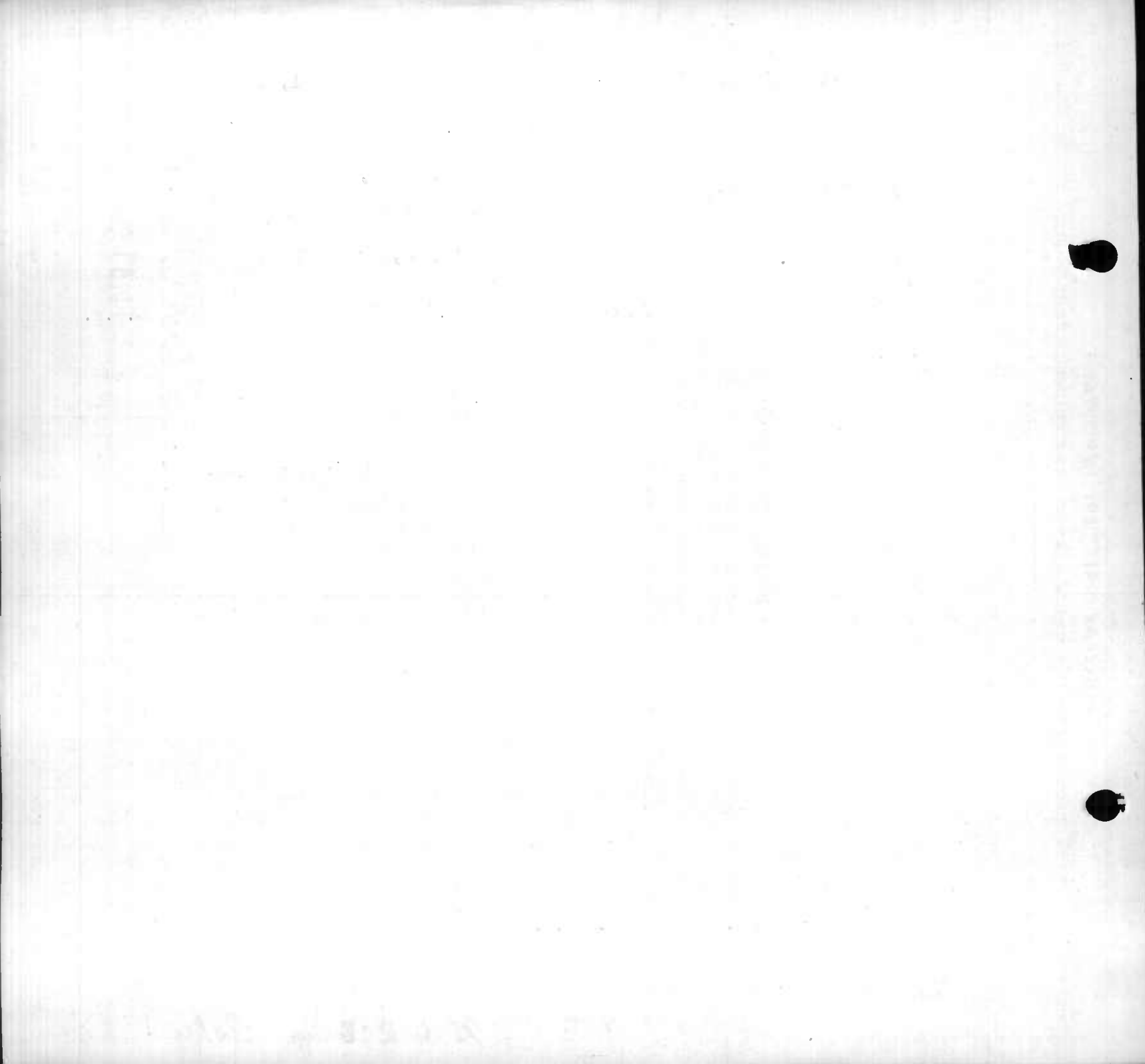
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5624 **CERTIFICATE OF DEATH**

REG. NO. 69 5624

| | | | | | |
|--|----------------------|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Cornelius Harris Johnson | | 2. DATE AND HOUR OF DEATH
June 1, 1969 6:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
2006 Division Street | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 14-03
C. CITY OR TOWN Baltimore,
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2006 Division Street | | |
| 5. SEX
Male | 6. RACE
N. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 16, 1894 | 9. AGE (In years last birthday)
75 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 13. FATHER'S NAME
Henry Johnson | | | 14. MOTHER'S MAIDEN NAME
Mildred Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Daisy Johnson
ADDRESS
2006 Division Street | |
| 18. 410.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Hypertensive Cardiovascular Disease
3 years | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) Ischemic
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
II | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1965 to May 1969 , that (I) was last saw the deceased alive on 22 May 1969 and that in (my) your opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
Simon H. Carter, Jr., M.D.
DEGREE | | | | 23B. DATE SIGNED
2 July | |
| 23C. PHYSICIAN'S NAME (Type)
Simon H. Carter, Jr., M.D. | | | | 23D. ADDRESS
4215 Park Heights Ave. 21215
DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
6/2-69 | | 24C. NAME OF CEMETERY or CREMATORY
Family Plot | |
| 24D. LOCATION (City, town, or county) (State)
Caroline Co. Va | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | |
| 25B. NAME OF REGISTRAR
George E. Talley, M.D. | | 25C. FUNERAL DIRECTOR
W. W. Dabney
ADDRESS
Ashland, Virginia | | | |



W-425

69 - 5635

BALTIMORE CITY HEALTH DEPARTMENT

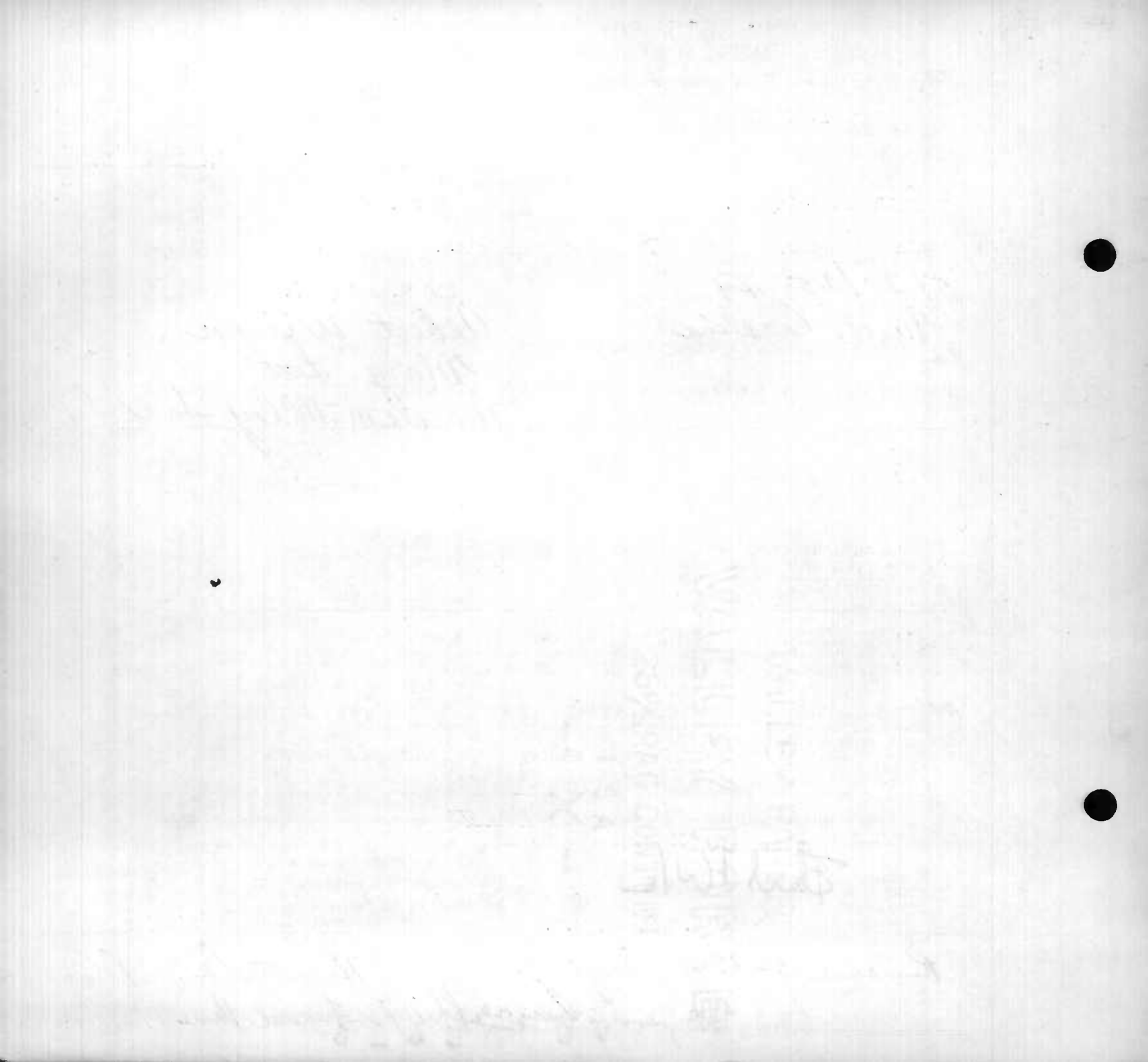
69 5635

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
MATTHEW WILSON | | | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
5 28 69 2:00 p.m. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
220 N. Amity St. | | | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 28, 1969 2:00 p.m. | | | |
| 6. SEX
Male | | | | 7. RACE
Colored | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
5/20/25 | | | | 10. AGE (In years lost birthday)
44 | | 11. BIRTHPLACE (State or foreign country)
North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY?
North Carolina | | | | 13. FATHER'S NAME
Robert Wilson | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 15. MOTHER'S MAIDEN NAME
Mary Lett | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Warren M. McCoy Sanford NC | |
| 19. 345.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Epilepsy | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Epilepsy | | | |
| 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 20A. DATE OF OPERATION
2 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 8/28/69 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
5-29-69 | | 24C. NAME OF CEMETERY or CREMATORY
Angery | | 24D. LOCATION (City, town, or county) (State)
Norfolk Co. NC | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
James E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Shilley Funeral Home | | ADDRESS
1727 N. Mount | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5636</u> |
|--|--|---|--|---|
| BIRTH NO. <u>69 5636</u> | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Margaret M. Gable</u> | | 2. DATE AND HOUR OF DEATH
<u>June 2, 1969</u> <u>7 A.</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

<u>00 33 E. Barney St.</u> | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>23-03</u> | | |
| 5. SEX <u>Female</u> 6. RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | |
| 13. FATHER'S NAME
<u>Frank Phillips</u> | | 14. MOTHER'S MAIDEN NAME
<u>Rose (Montgomery)</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>- - -</u> | | |
| 17. INFORMANT
<u>Mrs. Myrtle Becker (same as #4)</u> | | ADDRESS | | |
| 18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>Arteriosclerotic heart disease</u> years
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | |
| 19A. DATE OF OPERATION
<u>0</u> <u>none</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>none</u> | | |
| 20A. AUTOPSY? (Yes or No)
<u>no</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>none</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1968</u> <u>1968</u> to <u>June 2, 1969</u> <u>19</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1969</u> <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>C. C. Chiu, M. D.</u> | | 23B. DATE SIGNED
<u>June 2, 1969</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>C. C. Chiu, M. D.</u> | | 23D. ADDRESS
<u>1 E. Randall Street, Baltimore, Md. 21230</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6-5-1969</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Holy Cross Cemetery</u> |
| 24D. LOCATION
<u>Baltimore, Md.</u> | | 24E. (City, town, or county) (State) | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>McGully 130 E. Fort Ave. Balto. 21230</u> |
| 25D. ADDRESS | | 25E. (City, town, or county) (State) | | |

10/1/1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

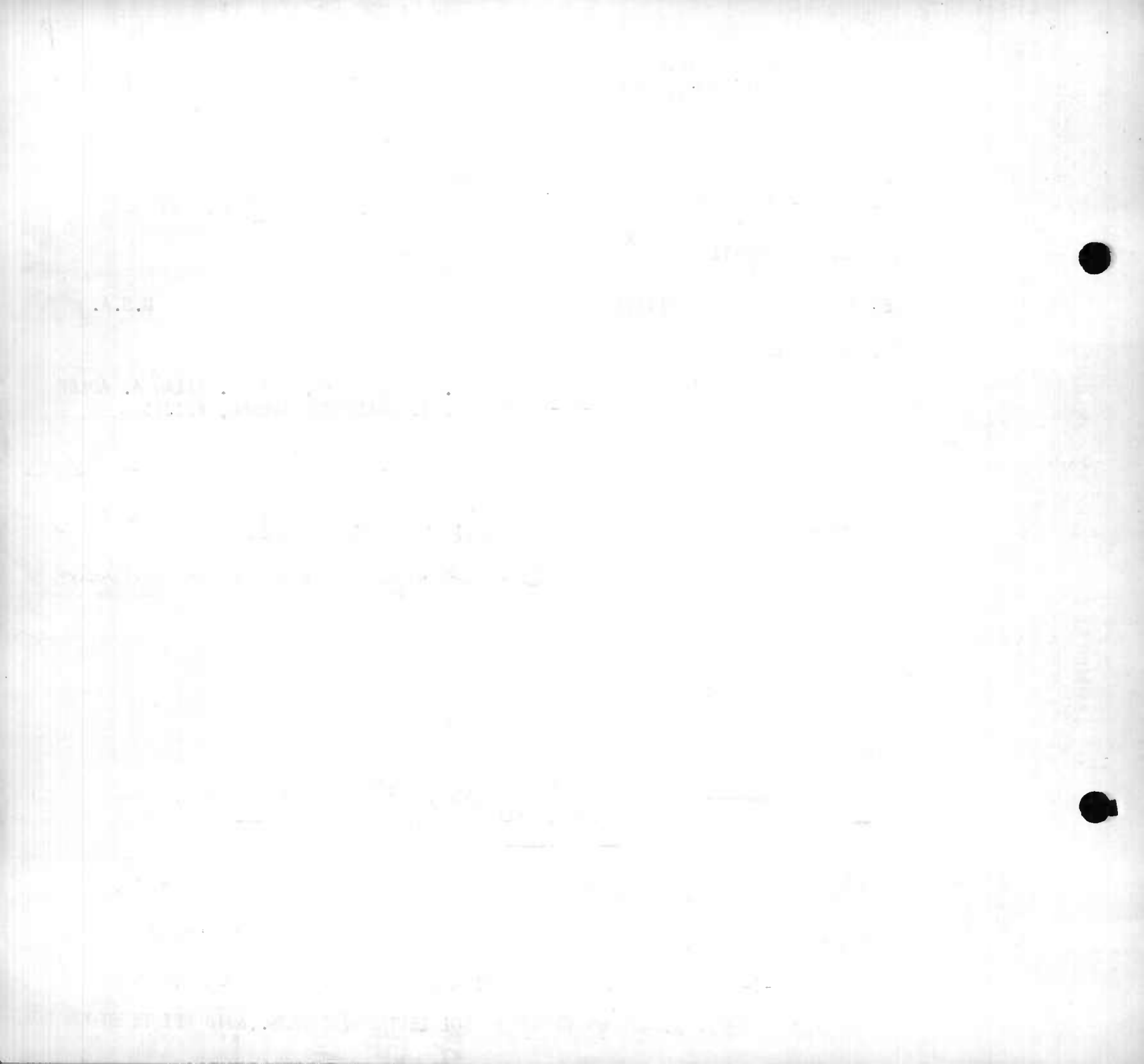
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 69 5637 |
|---|------------------|--|---|--|--|
| A-346 | | 69 5637 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | HENRY
Charles Adler | | May 30, 1969 9 ³⁰ A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE
B. COUNTY | | |
| Sinai Hospital of Baltimore, Inc. | | | Maryland | | |
| | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
4623 Park Heights Ave | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
xxxxxx | 9. AGE (In years last birthday)
80 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SALESMAN | | 10B. KIND OF BUSINESS OR INDUSTRY
RETAIL | | 11. BIRTHPLACE (State or foreign country)
Russia | |
| 13. FATHER'S NAME
RABBI LEVI ADLER | | 14. MOTHER'S MAIDEN NAME
RAY ? | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
215-01-6580A | | 17. INFORMANT
MRS. SYDEL ADLER, c/o MR. ALLAN A. ADLER
5013 CHALGROVE AVENUE, #21215 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Pulmonary embolus

(B)
DUE TO, OR AS A CONSEQUENCE OF:
Phlebitis @ calf

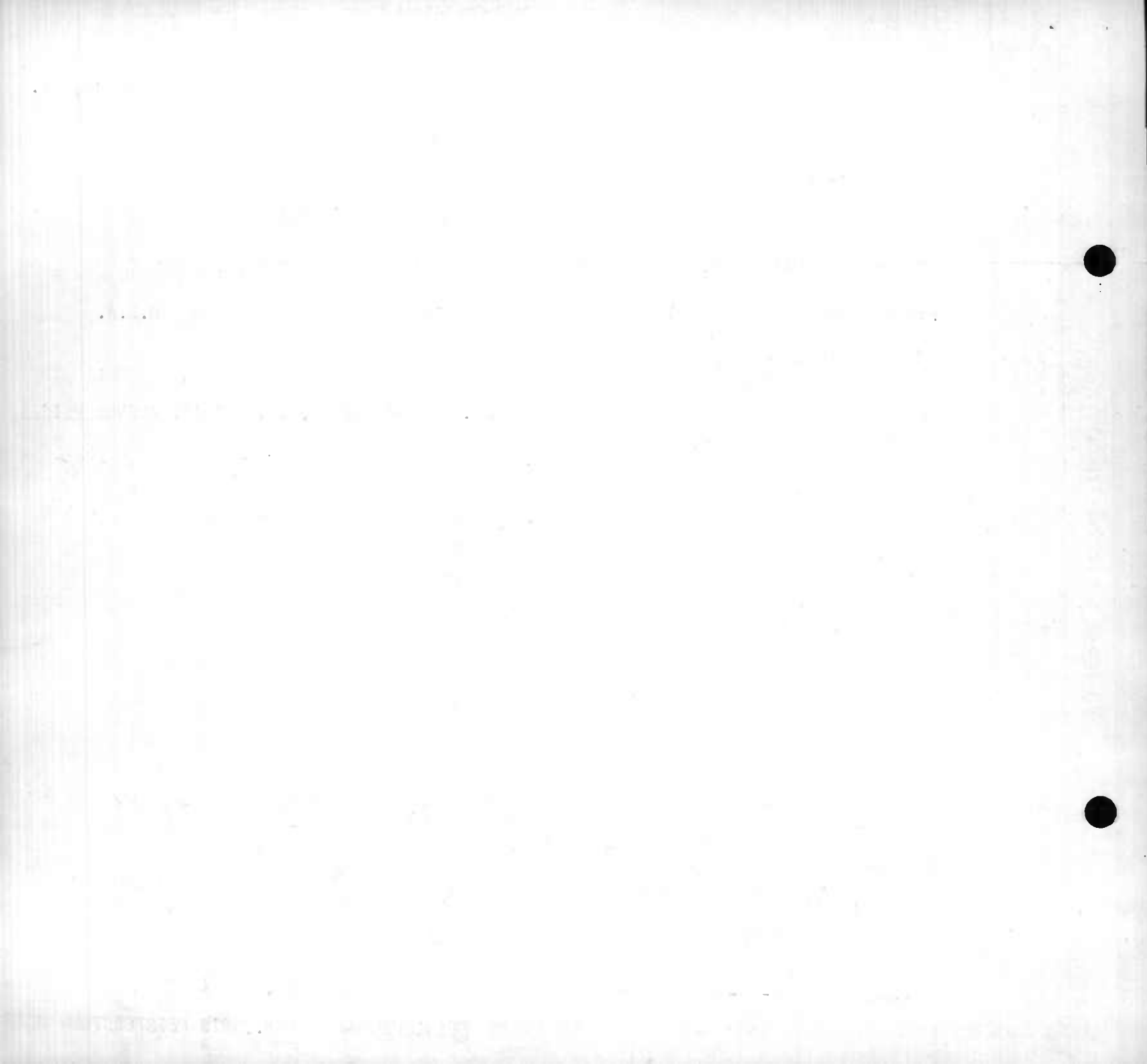
(C)
DUE TO, OR AS A CONSEQUENCE OF:
Overwhelming pneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hours
3 days
11 days |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 19, 1969 to May 30, 1969, that (I) (we) last saw the deceased alive on May 30, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Barry Green, M.D. | | | | 23B. DATE SIGNED
5/30/69 | |
| 23C. PHYSICIAN'S NAME (Type)
Barry Green, M.D. | | | | 23D. ADDRESS
Sinai Hospital of Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-1-69 | | 24C. NAME OF CEMETERY or CREMATORY
AN SHE SFARD
OHR KNESSETH ISRAEL XXXX | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, Jr. | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

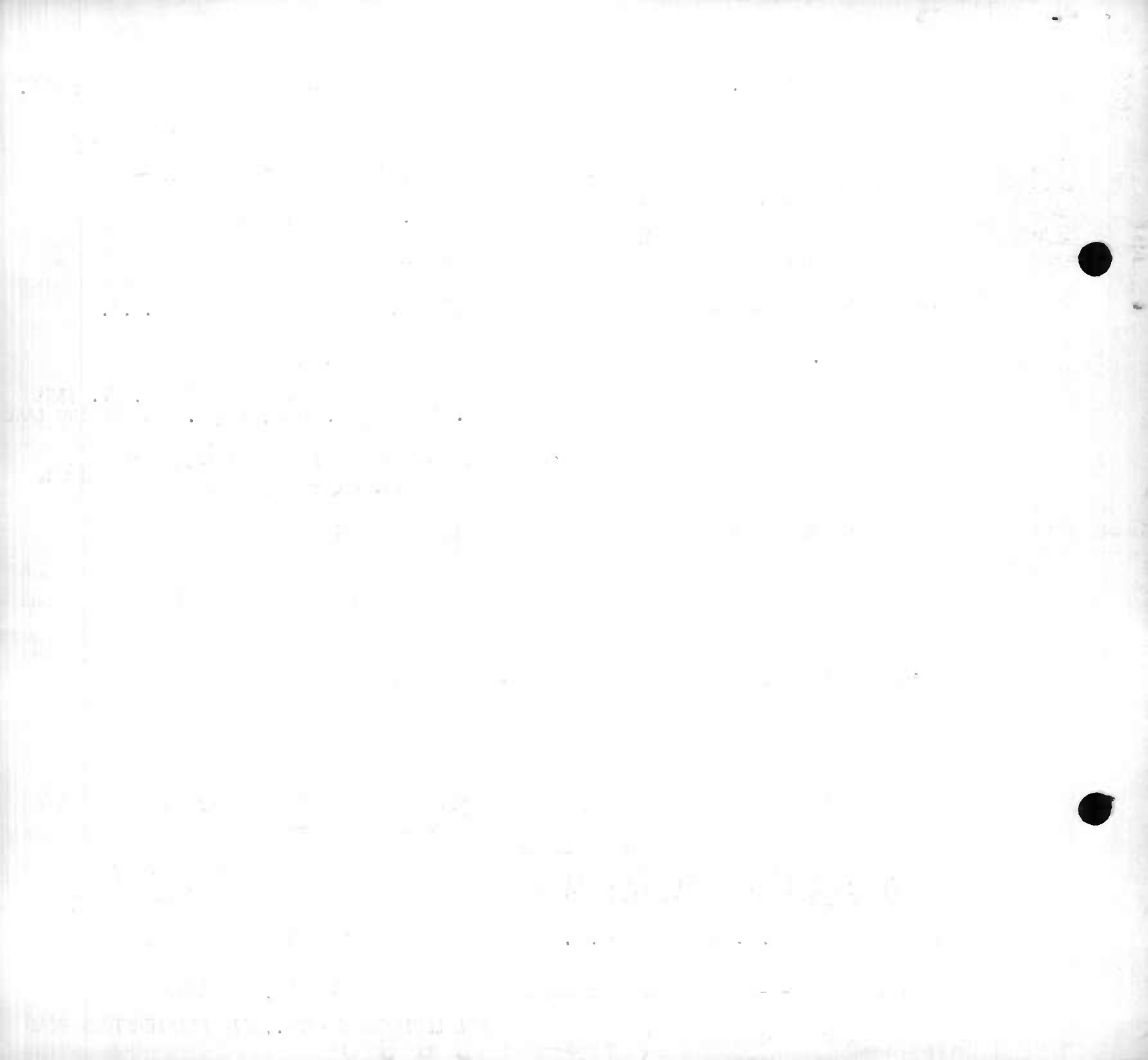
| 5-350 69 5638 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5638 | |
|--|---------|--|------------------|---|-----------------------------|--|------------------------------|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | ANNA STEIN | | MAY 28, 1969 10:09 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY | | 15-12 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | MARYLAND | | C. CITY OR TOWN | |
| 2911 VIOLET AVENUE | | | | BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | 2911 VIOLET AVENUE | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | 12. CITIZEN OF WHAT COUNTRY? |
| FEMALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 83 | | | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| HOUSEWIFE | | AT HOME | | RUSSIA | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| ? MICHELSON | | | | ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | | | MR. ABRAHAM STEIN, 2911 VIOLET AVENUE #21215 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| I | | | | acute myocardial infarction | | 1 day | |
| ANTECEDENT CAUSES | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | arteriosclerotic heart disease | | 5 years. | |
| II | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | none | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1, 1966 to May 28, 1969, that (I) (we) last saw the deceased alive on May 28, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Manuel Levin | | | | | | 5/29/69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| MANUEL LEVIN | | | | 6101 PARK HEIGHTS AVENUE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 5-30-1969 | | RUDOMER VEREIN | | ROSEDALE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUN 3 1969 | | Robert E. Galt, M.D. | | SPL LEVINSON & BROS. | | 6010 REISTERSTOWN ROAD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

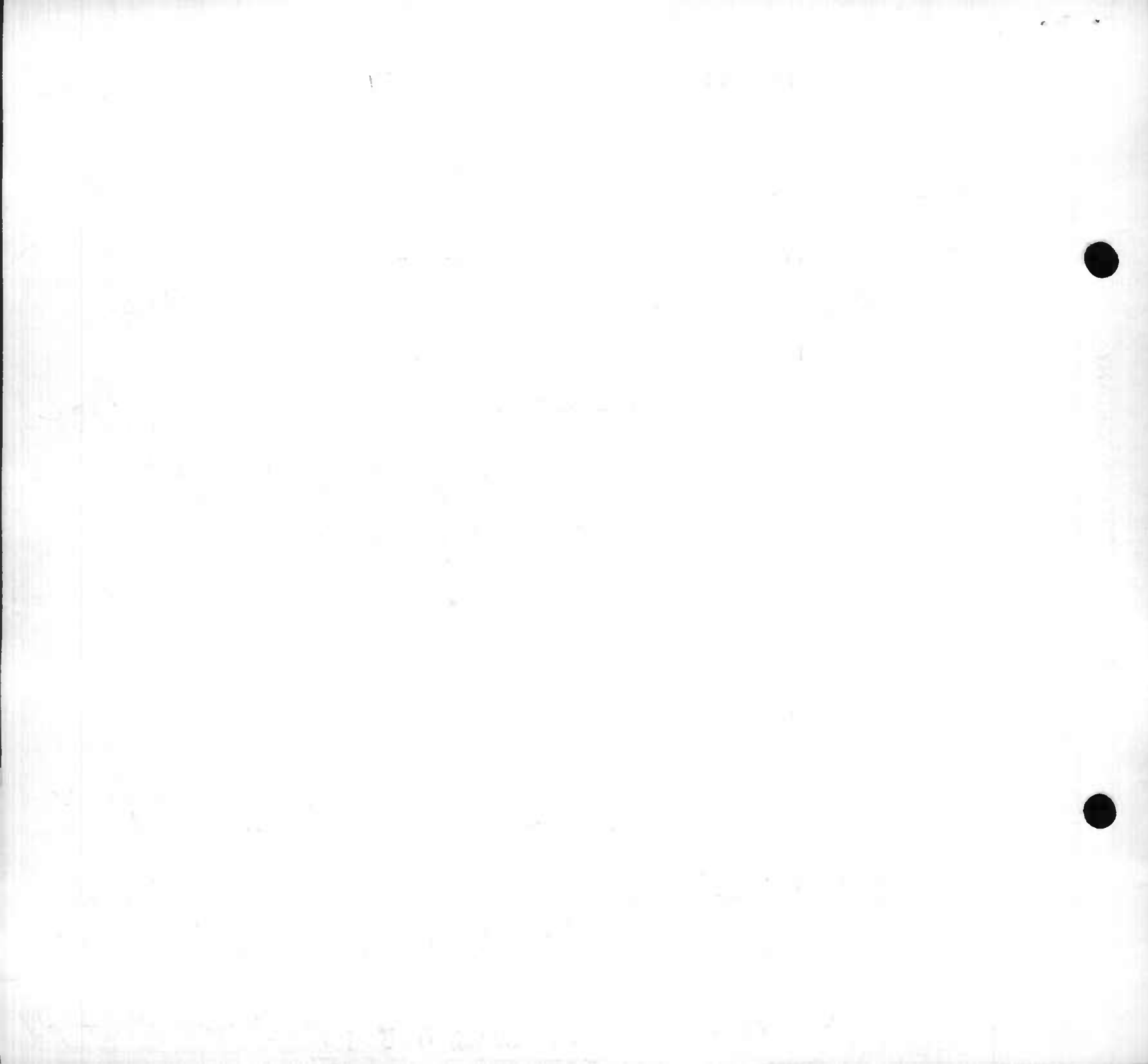
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|---|--|---|--|---|--|------------------------------------|
| BIRTH NO. 69 5639 | | | | | | | | | |
| REG. NO. 69 5639 | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) LEON XX. BLOCK | | | | | 2. DATE AND HOUR OF DEATH
6-1-69 9:00A.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY 27-11 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL
33 BALTIMORE, MD 21205 | | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX MALE | | | | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2-21-05 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
INVESTMENT BANKER | | | | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
SIMON J. BLOCK | | | | | 14. MOTHER'S MAIDEN NAME
RAE HANLINE | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MRS. JOAN BLOCK, 404E, 100 W. COLD SPRING LANE | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
154.1 I METASTATIC CARCINOMA OF RECTUM
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
3 yrs | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
5/11/69 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
INTESTINAL OBSTRUCTION | | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 5/11/69 to 6/1/69 and that (we) lost saw the deceased alive on 6/1/69 and that (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
JAMES R.K. CONDON M.D. | | | | | | | | 23B. DATE SIGNED
6/1/69 | |
| 23C. PHYSICIAN'S NAME (Typed)
JAMES R.K. CONDON M.D. | | | | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | 24B. DATE
6-2-69 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE HEBREW | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | 25B. NAME OF REGISTRAR
JAMES R. CONDON M.D. | | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|------------------------------------|--|---|---|--|
| C-160 69 5640 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 69 5640 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) WOLF CWEIBER | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 2. DATE AND HOUR OF DEATH
31 May 1969 11:20 AM | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
BALTIMORE, MD 21205 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE | | 53-00 | |
| C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | E. STREET AND NUMBER
811 JUDY LANE | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-17-03 | 9. AGE (In years last birthday)
66 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Merchant | | 10B. KIND OF BUSINESS OR INDUSTRY
Childrens Wear | | 11. BIRTHPLACE (State or foreign country)
Poland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
JACOB CWEIBER | | | | 14. MOTHER'S MAIDEN NAME
FANNIE KAGEN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
119-18-6452 | | 17. INFORMANT
Sonia Cweiber 811 Judy Lane | | | |
| 18. 412.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
multiple myocardial infarct 4 yrs.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic heart disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 yrs. | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 May 1969 to 31 May 1969 that (I) last saw the deceased alive on 31 May 1969 and that (in my) own opinion death occurred on the date and hour and from the causes stated above. (I) we (did) not view the body after death. | | | | | | | |
| 23A. SIGNATURE
Robert A. Norum M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
31 May 69 | |
| 23C. PHYSICIAN'S NAME (Type)
Robert A. Norum M.D. | | | | 23D. ADDRESS
Johns Hopkins Hospital Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
June 1/69 | | 24C. NAME OF CEMETERY or CREMATORY
Chuzzle Amund | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR
Sal... Inc | | ADDRESS
6010 Keet. Rd | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) *CHARLES HARRY E. LONESOME GAMBLE* 2. DATE OF DEATH Known ☐ Month Day Year Hour Estimated ☒ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3. DATE PRONOUNCED DEAD Month Day Year Hour
May 25, 1969 6:30 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 20-04

6. SEX male 7. RACE negro 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH 6-19-1933 10. AGE (In years lost birthday) 35 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER 2103 W. Boyd Street

11. BIRTHPLACE (State or foreign country) BALTIMORE MD 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles E. Lonesome

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed 14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME Phoebe E. Young

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) NO 17. SOCIAL SECURITY NO.

18. INFORMANT ADDRESS Ernestine Coleman 2314 Round Rd

19. 304.9 I CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

Intravenous narcotism

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Yes

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Werner U. Spink* M.D. EXAMINER'S NAME (Type) Werner U. Spink, M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 5/2 6/69

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 5/2/69 24C. NAME OF CEMETERY or CREMATORY Mt Airy 24D. LOCATION (City, town, or county) (State) Baltimore MD

25A. DATE REC'D BY HEALTH DEPT. JUN 3 1969 25B. NAME OF REGISTRAR Robert E. Farber, M.D. 25C. FUNERAL DIRECTOR ADDRESS Markham P. Lyons 6814 St

VS177 signed by Dr. Spitz

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--------------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5642 | |
| BIRTH NO. | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>Reason G Ross</u> | | 2. DATE AND HOUR OF DEATH
<u>May 30, 1969</u> <u>9:45 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Johns Hopkins Hospital</u>
<u>601 N. BROADWAY, BALTO. MD 21205</u> | | A. STATE <u>Maryland</u>
B. COUNTY <u>AD</u>
C. CITY OR TOWN <u>Pasadena</u>
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <u>Box 556 RT #3 (Mt. Rd.)</u> | |
| 5. SEX <u>Male</u> | 6. RACE <u>Caucasian</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-25-54</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Student</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>School</u> | 9. AGE (in years last birthday) <u>14yo</u> |
| 11. BIRTHPLACE (State or foreign country)
<u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>ERNEST TURNER</u> | | 14. MOTHER'S MAIDEN NAME
<u>BETTY L. ROSS</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>Mrs Betty Ross (Mother)</u> | | ADDRESS <u>Same AS #4</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>582 X I</u> | | CAUSE OF DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Uremia, Acidosis, Anuria</u> | |
| | | (B) <u>Renal Failure - Chronic</u> | |
| | | (C) <u>Chronic Glomerulonephritis</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>Malnutrition</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 weeks</u>
<u>3 yrs</u>
<u>4 yrs</u>
<u>2 yrs</u> | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____
that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<u>Richard W. Kester</u> | | 23B. DATE SIGNED
<u>5/30/69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Richard W. Kester</u> | | 23D. ADDRESS
<u>601 N. BROADWAY BALTO. MD</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/2/69</u> | |
| 24C. NAME OF CEMETERY OR CREMATORY
<u>Meadowridge Memorial Park</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Elkridge, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | 25B. NAME OF REGISTRAR
<u>Wm E. Gabery, M.D.</u> | |
| 25C. FUNERAL DIRECTOR
<u>E. B. Fleming</u> | | ADDRESS
<u>Singleton Funeral Home, 4147 Burnside</u> | |

X

(1914)

11 22 14

School

State - State - The State (1914) 11 22 14

General School Management (1914) 11 22 14

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5643

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 5643

| | | | | | |
|---|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Uhl Marie Frieda</i> | | 2. DATE AND HOUR OF DEATH
<i>6-2-69 7:03 AM</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>MD</i> B. COUNTY <i>Balt.</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>38 University Hosp. Balt.</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <i>Balt.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <i>F</i> | | 6. RACE <i>white</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Sales girl</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Hutzlers co.</i> | | 8. DATE OF BIRTH <i>8-14-07</i> | |
| 13. FATHER'S NAME
<i>William Hershfeld</i> | | 14. MOTHER'S MAIDEN NAME
<i>Freda Miller</i> | | 9. AGE (in years last birthday) <i>61</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>no</i> | | 16. SOCIAL SECURITY NO.
<i>220-14-4563</i> | | 17. INFORMANT <i>husband</i> ADDRESS <i>604 N. Patomac St.</i> | |
| 18. CAUSE OF DEATH
I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>Brain injury (due to operation)</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Brain tumor</i>
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>12 months</i> | |
| 19A. DATE OF OPERATION
<i>5-28-69</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>good</i> | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5-28</i> 19 <i>69</i> to <i>6-2</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>7:03 AM 6-2</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Alphonsus Khan M.D.</i> | | | | 23B. DATE SIGNED
<i>6-2-69</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
<i>University Hosp. Balt. and</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6/5/69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Oak Lawn Cemetery</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Schimmek Funeral Home, Inc.</i> | |
| | | | | ADDRESS
<i>3331 Brahms Lane</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|--|--|--|---|---|---|--|--|
| 69 5644 | | | | | REG. NO. 69 5644 | | | | |
| BIRTH NO. | | | | | 1. NAME OF DECEASED <i>Susan</i> | | | | |
| (Type or Print) <i>MARGARET WICK</i> | | | | | 2. DATE AND HOUR OF DEATH <i>11.50 pm. 5/29/69</i> M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>Mercy Hospital</i> | | | | | A. STATE <i>2704 Haley Ave. 27-33</i> | | | | |
| | | | | | C. CITY OR TOWN <i>Balto. Md</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| E. STREET AND NUMBER | | | | | | | | | |
| 5. SEX <i>2</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>3-26-15</i> | | 9. AGE (In years last birthday) <i>54</i> | | If Under 1 Yr. Months Days | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Lord Balto. Press</i> | | 11. BIRTHPLACE (State or foreign country) <i>Conn.</i> | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <i>James Baxter</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Bertha Upton</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. <i>048-12-3381</i> | | 17. INFORMANT <i>Alma J. Penman, dght. 6221 Pioneer Dr.</i> | | |
| 18. <i>458.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardio-resp. failure</i> | | | | |
| ANTECEDENT CAUSES | | | | | (B) <i>Cor pulmonale - pul. fibrosis</i> | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (C) <i>intracranial hemorrhage</i> | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <i>5/27/69</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Chronic Art. occlusion</i> | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5/10/69</i> 19 to <i>5/29/69</i> 19 | | | | | | | | | |
| that (I) (we) last saw the deceased alive on <i>5/29/69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Ying-Sek Chan</i> M.D. DEGREE | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <i>YING-SEK CHAN</i> M.D. DEGREE | | | | | 23D. ADDRESS <i>Mercy Hospital</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>6/2/69</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i> | | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JUN 3 1969</i> | | | 25B. NAME OF REGISTRAR <i>John E. Sabe, M.D.</i> | | | 25C. FUNERAL DIRECTOR <i>Schmunk Funeral Home, Inc.</i> ADDRESS <i>3831 Browns Lane</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5645 | |
|--|---------|--|---|--|---|
| <div style="display: flex; justify-content: space-between;"> 69 5645 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | HUGH ALBERT McGOWAN | | 5/30/69 3:30 a. m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| 00 601 N. East Ave. | | | Md., 21205 26-10 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 601 N. East Avenue | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days |
| male | white | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 10/1/91 | 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Foreman | | Pa. R. R. | | Pennsylvania | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Hugh McGowan | | | Caroline Miner | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | 717-07-6969 | | Juliette Nicklas McGowan, wife, above | |
| 18. CAUSE OF DEATH | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> </div> <div style="width: 10%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>410.9 I</p> <p>Acute Myocardial Infarction</p> </div> <div style="width: 45%;"> <p>5 minutes</p> </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> </div> <div style="width: 45%;"> <p>10 years</p> </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Pulmonary Emphysema</p> </div> <div style="width: 45%;"> <p>10 years</p> </div> </div> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 1968 to 5/30 1969, that (H) (we) last saw the deceased alive on 5/30 1969 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (die) not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Leon Kassel | | | | 6/2/69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Dr. Leon Kassel | | | | 3501 St. Paul St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 6/3/69 | | Gardens of Faith | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUN 3 1969 | | E. E. E. E. E. | | Schimunek Funeral Home, Inc. 3331 Brehms Lane | |

1
J-200

69 5646 BALTIMORE CITY HEALTH DEPARTMENT

69 5646

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

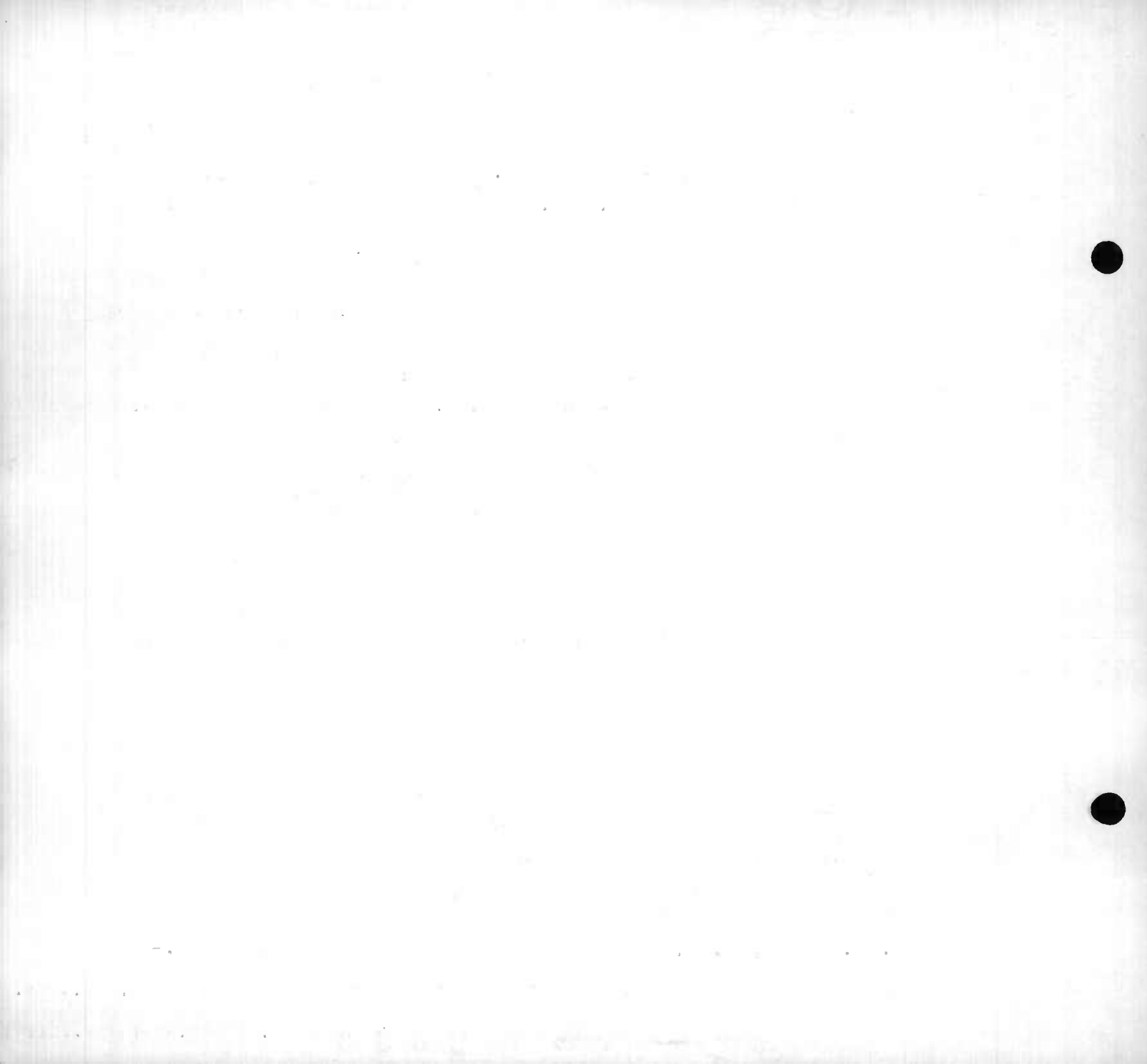
BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
DAN JACK | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
6 1 69 3:20 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
38 University Hospital | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 1, 1969 3:20 a.m. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
8-11-1952 | | 10. AGE (In years lost birthday)
16 | |
| 11. BIRTHPLACE (State or foreign country)
West Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
labor | | 14B. KIND OF BUSINESS OR INDUSTRY
Horse Farm | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 17. SOCIAL SECURITY NO.
? | |
| 18. INFORMANT
Mrs Beatrice A. Jack | | ADDRESS
C/O J. VAN BAK Ranch, 3 mth funeral home | |
| 19. E815.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Craniocerebral injuries
DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION
0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Road | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
St. Rt. 543 & 136 | | 22F. HOW DID INJURY OCCUR?
Subject passenger in auto-fixed object coll, | |
| 22D. TIME OF INJURY (APPROX.)
4 5 69 5:00a | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| ACTUAL SIGNATURE
Edward F. Wilson | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Edward F. Wilson, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-4-69 | |
| 24C. NAME of CEMETERY or CREMATORY
Beard Cemetery | | 24D. LOCATION (City, town, or county) (State)
Hillbury W. Va | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Wm Cook - Brooks | |
| 25C. FUNERAL DIRECTOR
Wm Cook - Brooks | | ADDRESS
1050 York Rd Towson Town md | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5647 | |
|--|-------------------------|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> 69 5647 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | BESSIE BRADY EMORY | | May 30, 1969 <i>one P M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
AT HER RESIDENCE: 1307 Bolton St. Balto., Md. | | | A. STATE
Maryland | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | C. CITY OR TOWN
Baltimore City | | |
| E. STREET AND NUMBER
1307 Bolton Street | | | 21217 | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 7, 1881 | 9. AGE (In years lost birthday)
87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore County, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Samuel Brady | | 14. MOTHER'S MAIDEN NAME
Helen Slingluff | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. (T)
220-44-4317 | | 17. INFORMANT: son ADDRESS
Wm. H. Emory, IV, 201 Oakdale Rd., City 21210 | |
| 18. 281.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
myocardial disease
gradual onset
marked malnutrition
anemia
gradual onset | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
one yr | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
myocardial disease
gradual onset
marked malnutrition
anemia
gradual onset | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1945 to May 30 1969 , that (I) (we) last saw the deceased alive on May 30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>W. H. Woody</i> | | | | 23B. DATE SIGNED
6-2-69 | |
| 23C. PHYSICIAN'S NAME (Type)
W. H. Woody, M. D. | | | | 23D. ADDRESS
1403 Park Avenue, Balto.-Md 21217 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6/ 2/ 1969 | | 24C. NAME OF CEMETERY or CREMATORY
St. Thomas' Cemetery - Garrison Forest, Balto. Co., Md. | |
| 24D. LOCATION (City, town, or county) (State) | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
JUN 3 1969 | | 25C. FUNERAL DIRECTOR
STEWART & MOWEN CO. 108 W. North Av., City 1 | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) Carol
DIANE CLARK | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> 6 2 69 3:10 a. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(If not in hospital or nursing home, give address of institution)
38 University Hospital 6-6-69 | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 2, 1969 3:10 a.m. | |
| 4. SEX Female | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Anne Arundel | |
| 7. RACE White | | C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER Road 354 Dutch Ship (North Shore) | |
| 9. DATE OF BIRTH 1950 May 30, 1969 | | 10. AGE (In years lost birthday) 19 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Clark | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | |
| 15. MOTHER'S MAIDEN NAME Elaine Disney | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None | |
| 17. SOCIAL SECURITY NO. Unknown | | 18. INFORMANT Mr. Thomas Clark (father) Same as #5 | |
| 19. E890 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Burns
DUE TO, OR AS A CONSEQUENCE OF:
(A) IMMEDIATE CAUSE Burns
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) Partial | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Garage | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? ? 354 Dutch Ship (North Shore) | | 22D. TIME OF INJURY (APPROX.) 5 28 69 4:30am. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Conflagration | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> P Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Edward F. Wilson
EXAMINER'S NAME (Type) Edward F. Wilson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED June 2, 1969 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE June 4, 1969 | |
| 24C. NAME OF CEMETERY or CREMATORY Friendship Cemetery | | 24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 3 1969 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Singleton Funeral Home | | 25D. ADDRESS Glen Burnie, Md. | |

VS 153 6-6-69 M. H.

SECURITY IS ASSURED

101527P

101527P

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>69 5649</u> |
|---|--|---|--|---|
| 1. NAME OF DECEASED
(Type or Print) BAXLEY, Edward Clifton | | 2. DATE AND HOUR OF DEATH
5-30-69 11:15 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 13-06 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
23 Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX Male | | 6. RACE Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Meat Cutter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
6-14-00 |
| 13. FATHER'S NAME
Peter F. Baxley | | 14. MOTHER'S MAIDEN NAME
Clara Bell | | 9. AGE (In years last birthday)
68 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 7-26-44 to 6-10-45 | | 16. SOCIAL SECURITY NO.
220-09-06-97 | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland |
| 17. INFORMANT VA Hospital Records | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 18. 519.2 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Uremia
DUE TO, OR AS A CONSEQUENCE OF: Chronic Urinary Obstruction
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 Months | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Pneumonia
DUE TO, OR AS A CONSEQUENCE OF:
Chronic Obstructive Pulmonary Disease
2 Weeks
Years | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that 00 (this hospital) attended the deceased from May 25, 19 69 to May 30, 19 69 that (X) (we) last saw the deceased alive on May 30, 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. 00 (We) (did) 000000 view the body after death. | | | | |
| 23A. SIGNATURE
<i>Maicia C. Schmidt</i>
MAICIA C. SCHMIDT | | 23B. DATE SIGNED
5/30/69 | | 23C. PHYSICIAN'S NAME (Type)
MD |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/3/69 | | 24C. NAME OF CEMETERY or CREMATORY
National |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, R.D.</i> | | 25C. FUNERAL DIRECTOR
Paul E. Chenoweth |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | ADDRESS
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | |

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FUNERAL DIRECTOR: IMPORTANT

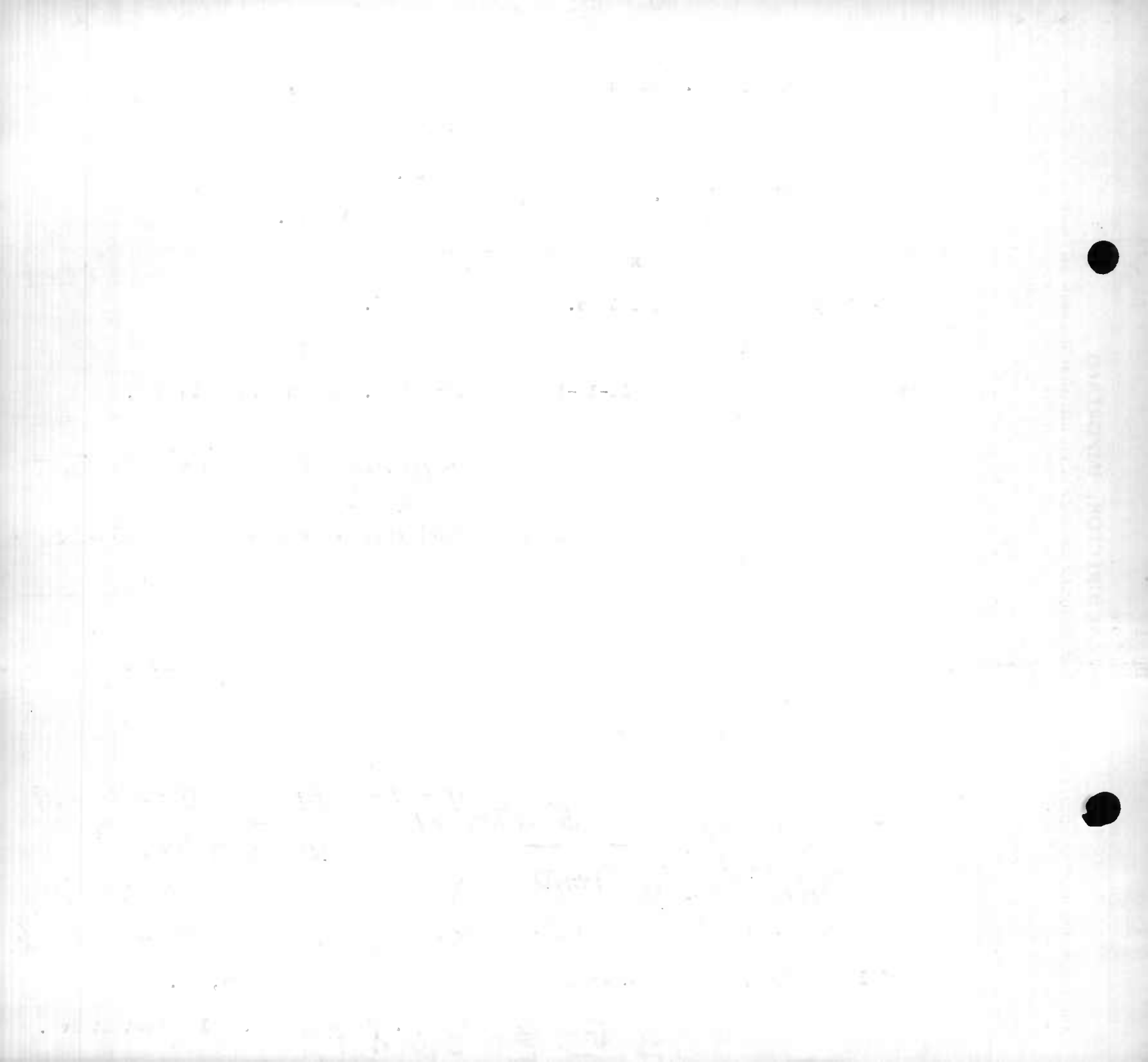
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5650 | |
|---|---------------------|---|---|--|--|
| BIRTH NO. 69 5650 | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
Margaret A. Putman | | | 2. DATE AND HOUR OF DEATH
May 27, 1969 M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 3213 Abell Ave. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Md. B. COUNTY 12-02 | | |
| | | | C. CITY OR TOWN
Balto. | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
3213 Abell Ave. | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/6/97 | 9. AGE (In years last birthday)
72 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Saleslady | | 10B. KIND OF BUSINESS OR INDUSTRY
Hecht Co. | | 11. BIRTHPLACE (State or foreign country)
Md. | |
| 13. FATHER'S NAME
? | | | 14. MOTHER'S MAIDEN NAME
? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
212-14-1899 | | 17. INFORMANT
Bernard R. Putman Hagerstown Md | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Coronary Thrombosis Instant
(B) Gen. Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 yrs |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-11-1951 to 5-27-1969 , that (I) was last saw the deceased alive on 5-27-1969 and that in (my) last apinlan death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. 10:50 A.M. | | | | | |
| 23A. SIGNATURE
Robert E. Siver M.D. | | | | 23B. DATE SIGNED
5-29-69 | |
| 23C. PHYSICIAN'S NAME (Type)
R.H. Siver M.D. | | | | 23D. ADDRESS
3105 N. Charles St. Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/30/69 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Hope | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Woodsboro, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Siver M.D. | | 25C. FUNERAL DIRECTOR
Paul E. Chenoweth Jr. | |
| | | | | ADDRESS
3617 Chestnut Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 69 5651 | |
|--|---|---|--|--|--|
| BIRTH NO. 69 5651 | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Clifford, Carl | | 2. DATE AND HOUR OF DEATH
5/28/69 12:30 Pm. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MD. B. COUNTY 27-88 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
+2 Sinai Hospital | | C. CITY OR TOWN
BALTO. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
5326 Nelson Ave | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6-1-25 | 9. AGE (In years last birthday)
43 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
Carling Brewery | | 11. BIRTHPLACE (State or foreign country)
MD.. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
WW2 12/44-11/46 | | 16. SOCIAL SECURITY NO.
214-18-1371 | | 17. INFORMANT
Audrey Clifford (same) | |
| 18. 201X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Hodgkin's Disease | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 mths. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 19 68 to May 1969 that (I) (we) last saw the deceased alive on 5/28 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Gerald B. Feldman MD | | 23B. DATE SIGNED
5/28/69 | | | |
| 23C. PHYSICIAN'S NAME (Type)
GERALD B. Feldman MD | | 23D. ADDRESS
Sinai Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
5/31/69 | 24C. NAME OF CEMETERY OR CREMATORY
Woodlawn | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
J. E. Gable, R.D. | | 25C. FUNERAL DIRECTOR
Paul E. Chonoweth Jr. ADDRESS
3617 Chestnut Ave. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
JOSEPH POLONCZYK | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
May 29, 1969 3:15 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
38 University Hospital | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 29, 1969 3:15 A.M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania B. COUNTY V-35 | |
| 9. DATE OF BIRTH
May 23, 1921 | | 10. AGE (In years lost birth day)
48 | |
| 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Shipping dept. | | 14B. KIND OF BUSINESS OR INDUSTRY
Retail Store | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
yes WW II | | 17. SOCIAL SECURITY NO.
169-12-9264 | |
| 13. FATHER'S NAME
Anthony Polonczyk | | 15. MOTHER'S MAIDEN NAME
Konstantia Schultz | |
| 18. INFORMANT
Medical Examiner | | ADDRESS
Baltimore, Maryland | |
| 19. E9881X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH
Rupture of venous angioma, lower cerebellum with massive subarachnoid hematoma, basal
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) Rupture of venous angioma, lower cerebellum with massive subarachnoid
DUE TO, OR AS A CONSEQUENCE OF:

(C) hematoma, basal | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | |
| 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>

ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED May 29, 1969
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-3-1969 | |
| 24C. NAME OF CEMETERY or CREMATORY
Holy Sepulchre Cemetery | | 24D. LOCATION (City, town, or county) (State)
Montgomery County, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Tabor, M.D. | |
| 25C. FUNERAL DIRECTOR
Raymond L. Kaczorowski | | ADDRESS
2525 Fleet St. | |

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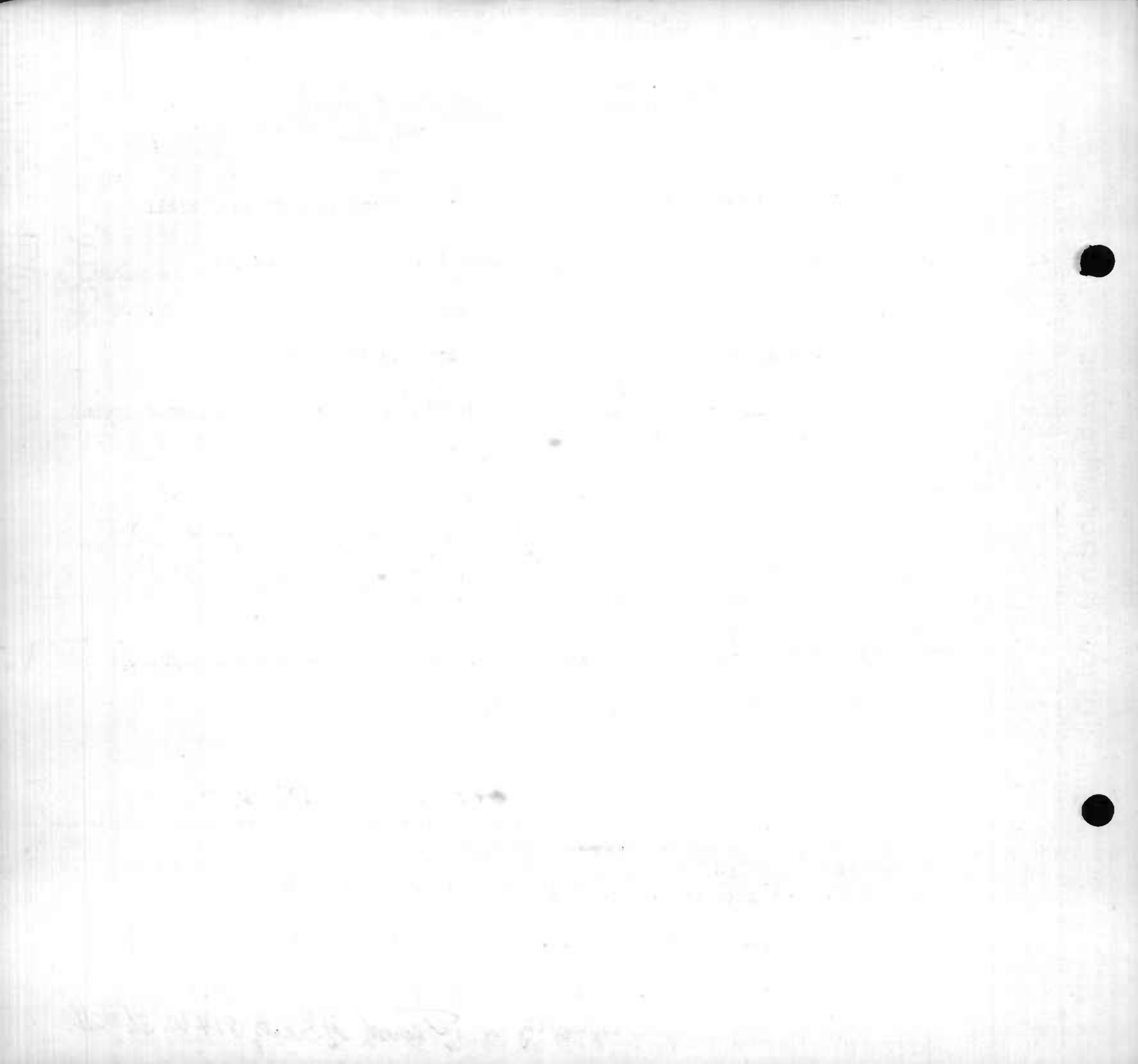
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
 REG. NO. **69 5653**

| | | | | | |
|---|-------------------------|---|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Jessie A. Johnson | | May 31, 1969 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

90 Mid-town Nursing Home | | | A. STATE
Maryland
B. COUNTY
13-48 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
Dellwood Avenue 21211 | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Mar 13, 1876 | 9. AGE (In years lost birthday)
93 yrs |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Jesse Brooks | | 14. MOTHER'S MAIDEN NAME
Mary McCauley | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
-- | | 17. INFORMANT
Jessie A. Johnson | |
| | | | | ADDRESS
Dellwood Avenue | |
| 18. 412.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cardio. Respiratory Failure | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Cong. hrt (Heart Failure)
(B) Arteriosclerosis (CVA)
DUE TO, OR AS A CONSEQUENCE OF:
(C) Senility - Hemiplegia (CVA) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 22 19 55 to May 31 19 69 , that (I) (we) last saw the deceased alive on May 31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Willard Applefeld | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
Willard Applefeld | | | | 23D. ADDRESS
M.D. 6615 Reisterstown Road | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/3/69 | | 24C. NAME of CEMETERY or CREMATORY
St. Marys Cemetery (Hampden) | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 24F. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 24G. DATE REC'D BY HEALTH DEPT. | | 24H. NAME OF REGISTRAR | | 24I. FUNERAL DIRECTOR
Frank H. Seitz | |
| | | | | ADDRESS
814 W. 36th St. | |



FUNERAL DIRECTOR: IMPORTANT

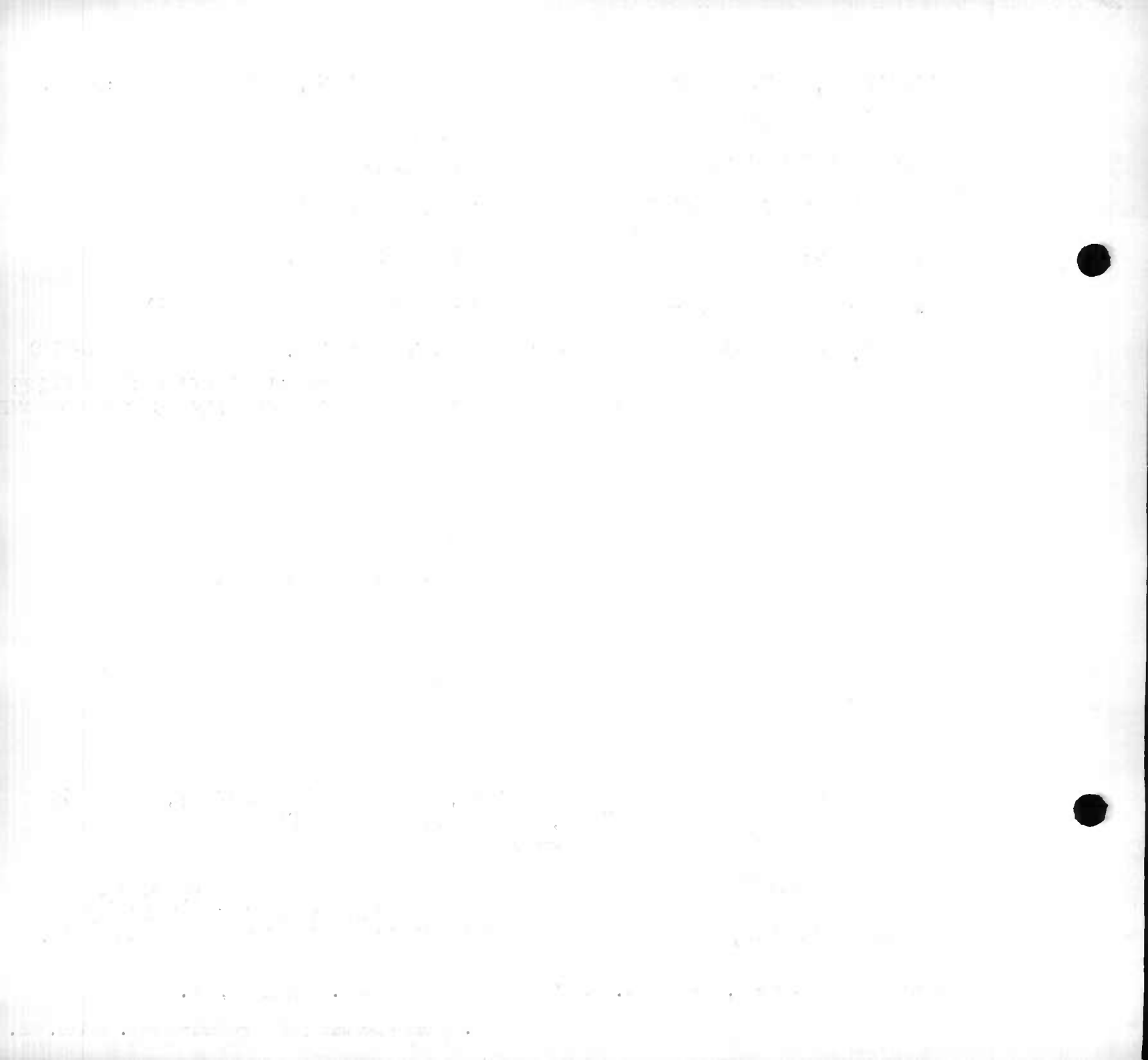
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5654 | |
|--|-------------------------|--|-----------------------------------|--|---|
| 54-29-53 1ajs | | 69 5654 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Charles FEESER</i> | | 2. DATE AND HOUR OF DEATH
<i>MAY 27 1969 12:30 PM</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)
A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>31 Baltimore City Hospital</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<i>ESSEX</i> | |
| 14940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | 531 DORSEY AVENUE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX
<i>MALE</i> | 6. RACE
<i>WHITE</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>7-1-10</i> | 9. AGE (In years last birthday)
<i>57</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>GARDNER</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>PENNSYLVANIA</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>GEORGE</i> | | 14. MOTHER'S MAIDEN NAME
<i>LYDIA LIGHTNER</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>YES</i> | | 16. SOCIAL SECURITY NO.
<i>218-03-9967</i> | | 17. INFORMANT
<i>BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.</i> | |
| 18. <i>320.9 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Cardio-respiratory arrest</i> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Meningo-encephalitis</i> | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | (D) DUE TO, OR AS A CONSEQUENCE OF: | | (E) DUE TO, OR AS A CONSEQUENCE OF: | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>5/27</i> <i>1969</i> to <i>5/27</i> <i>1969</i> , that (I) (we) last saw the deceased alive on <i>5/27</i> <i>1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>J. Torres</i> | | 23B. DATE SIGNED
<i>5-27-69</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>JOSE TORRES MD.</i> | |
| 23D. ADDRESS
<i>4940 EASTERN AVE. BALTIMORE, MARYLAND</i> | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>5/31/69</i> | |
| 24C. NAME OF CEMETERY or CREMATORY
<i>GARDENS OF FAITH</i> | | 24D. LOCATION
<i>BALTO. MD.</i> | | 24E. DATE REC'D BY HEALTH DEPT.
<i>JUN 3 1969</i> | |
| 24F. NAME OF REGISTRAR
<i>John E. Taylor, M.D.</i> | | 24G. FUNERAL DIRECTOR
<i>John J. Connelly</i> | | 24H. ADDRESS
<i>300 Main Ave</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5655</u> |
|--|-------------------------|--|-------------------------------------|---|
| BIRTH NO. <u>69 5655</u> | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type in full)
SCHNEIDER, JOHN EDWARD | | 2. DATE AND HOUR OF DEATH
MAY 29, 1969 11:30 A. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
ST AGNES HOSPITAL
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
WILKENS & CATON AVENUES
BALTIMORE MARYLAND 21229 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY <u>20-08</u>
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 210 S LOUDON AVENUE | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
05 28 11 | 9. AGE (in years lost birthday) 57 58 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Pasteurizer | | 10B. KIND OF BUSINESS OR INDUSTRY
Dairy | | 11. BIRTHPLACE (State or foreign country)
MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
JOHN E. SCHNEIDER DEC 'D | | |
| 14. MOTHER'S MAIDEN NAME
(KOASS) MARY E. DEC 'D | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
214 01 8363 | | |
| 16. SOCIAL SECURITY NO.
214 01 8363 | | 17. INFORMANT
RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE | | |
| 18. CAUSE OF DEATH
571.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
(A) IMMEDIATE CAUSE Liver Cirrhosis DUE TO, OR AS A CONSEQUENCE OF:
(B) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF:
(C) Non-Traumatic Left pneumothorax
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 16, 1969 to MAY 29, 1969 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on MAY 29, 1969 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (do not) view the body after death. | | | | |
| 23A. SIGNATURE
 | | 23B. DATE SIGNED
05 30 69 | | 23C. PHYSICIAN'S NAME (Type)
SALVADOR QUIROZ, MD |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
June 2, 1969 | | 24C. NAME OF CEMETERY or CREMATORY
St. John's Lutheran Church Cem. Parkville, Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
G. Truman Schwab | | 25C. FUNERAL DIRECTOR
3512 Frederick Ave. Balto. Md. |



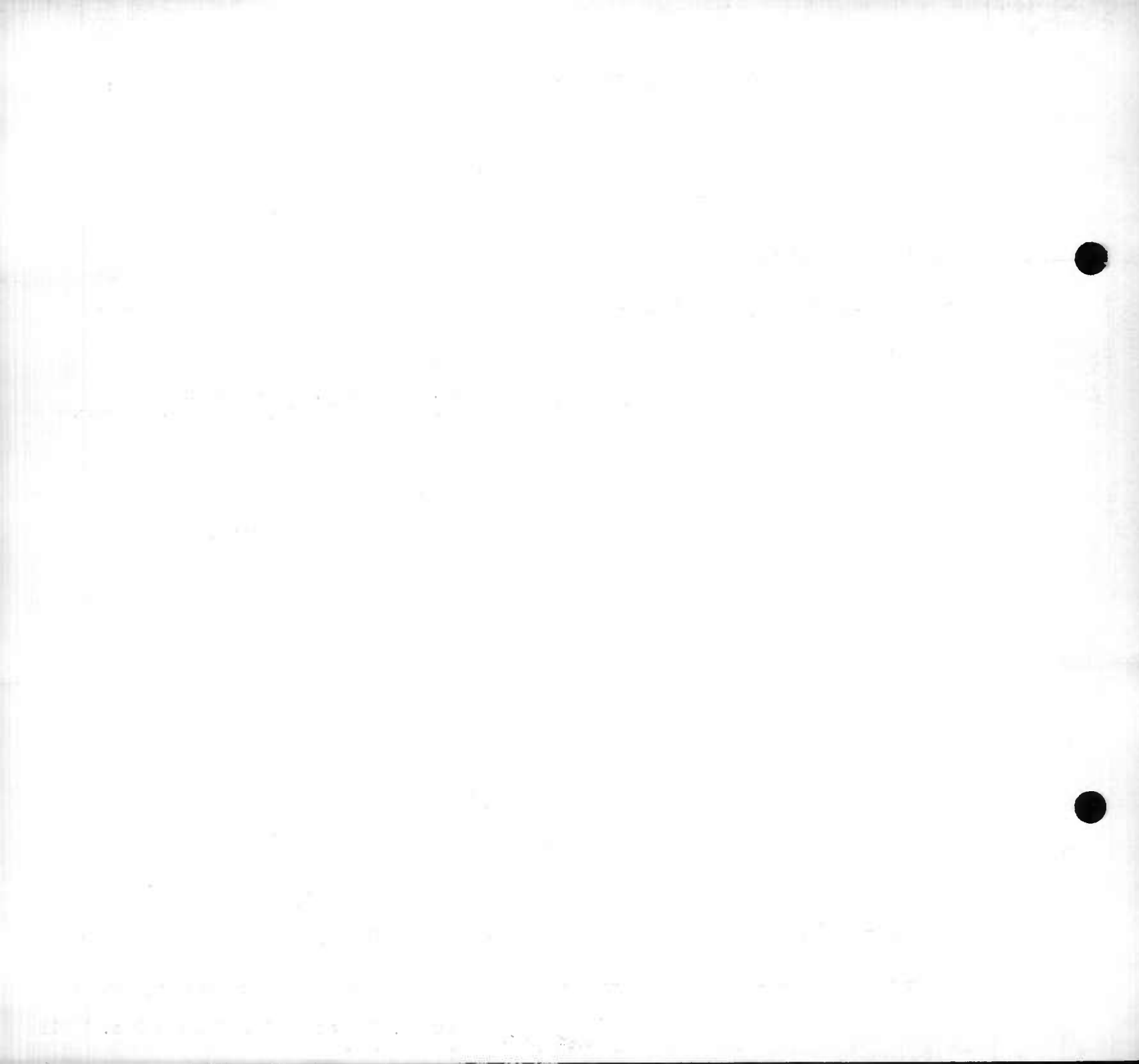
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5656

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5656

| | | | | | |
|--|------------------|---|------------------------------|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | SUZENBERGER, GEORGE | | MAY 31, 1969 7:10 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
10 ST AGNES HOSPITAL | | | | A. STATE
MARYLAND | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | B. COUNTY
25-51 | |
| | | | | C. CITY OR TOWN
BALTIMORE | |
| | | | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
3660 BENSON AVENUE | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
04 27 04 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED-MACHINIST | | 10B. KIND OF BUSINESS OR INDUSTRY
ARMCO STEEL | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
FRANK SUZENBERGER | | 14. MOTHER'S MAIDEN NAME
HELEN (SUZENBERGER) | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
216 05 7516 | | 17. INFORMANT
Mrs. Augusta W. Suzenberger,
3660 Benson Avenue | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
I This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
pneumonia embolism | | | | | |
| (B) Malignant polyp of colon (post-op) | | | | | |
| (C) Jaundice, GI Bleeding (post-op) | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION
May 22 69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Malignant polyp of colon | | 20A. AUTOPSY? (Yes or No)
NO. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from MAY 11 1969 to MAY 31 1969 that (X) (we) last saw the deceased alive on MAY 31 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Tse-Shiung Wu | | | | 23B. DATE SIGNED
5/31/69 | |
| 23C. PHYSICIAN'S NAME (Type)
TSE-SHIUNG WU | | | | 23D. ADDRESS
BALTIMORE MARYLAND 21229
ST AGNES HOSP. CATON & WILKENS AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-4-1969 | | 24C. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | |
| 24D. LOCATION
Dorsey, Howard County, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

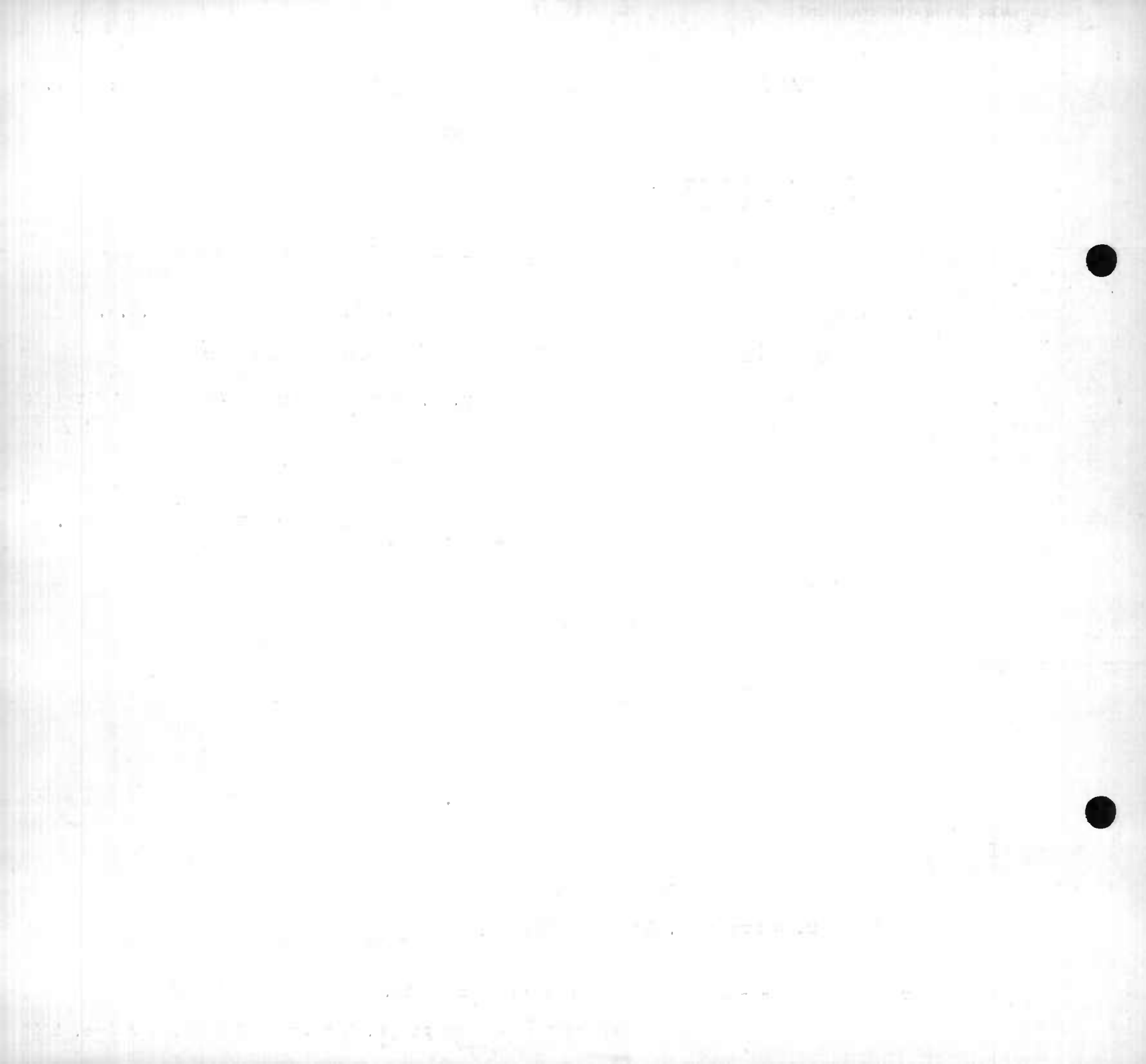
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|--|---|---|---|--|--|
| 69 5657 CERTIFICATE OF DEATH | | | | | REG. NO. 69 5657 | | | | |
| 1. NAME OF DECEASED
(Type or Print) NEWLIN, BLANCHE | | | | | 2. DATE AND HOUR OF DEATH
6-2-1969 3 A.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

9/Montebello State Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore Co. 53-00 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
9/Montebello State Hospital | | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | E. STREET AND NUMBER
4602 Leads Ave | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 9, 1882 | 9. AGE (In years last birthday)
87 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Montebello, Wis. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 13. FATHER'S NAME
Alex Shaw | | | | | 14. MOTHER'S MAIDEN NAME
(Unknown) | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Thelma Patterson, 4602 Leads Ave, Balt Md | | | | |
| 18. 433.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebral thrombosis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 years | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
NA | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
NA | | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NA | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
NA | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NA | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
NA | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
NA | | | 21F. HOW DID INJURY OCCUR?
NA | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-2-1965 to 6-2-1969 , that (I) (we) last saw the deceased alive on 6-2-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Nguyen Thi OANH, M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
6-2-1969 | |
| 23C. PHYSICIAN'S NAME (Type)
NGUYEN THI OANH, M.D. | | | | | 23D. ADDRESS
Montebello State Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-3-1969 | | 24C. NAME OF CEMETERY or CREMATORY
Woodlawn Cemetery | | | 24D. LOCATION (City, town, or county) (State)
Woodlawn, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | | | 25B. NAME OF REGISTRAR
James E. Jackson, M.D. | | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5658 | |
|---|-------------------------|---|--------------------------------------|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) EFFUS BUSH CLARK | | 2. DATE AND HOUR OF DEATH
June 1, 1969 1:15 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Virginia B. COUNTY Lancaster | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Gould Convalesarium
6116 Belair Road | | C. CITY OR TOWN
Lively | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-28-1881 | 9. AGE (In years lost birthday)
87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Robert Edward Bush | | 14. MOTHER'S MAIDEN NAME
Eudora Alexander | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mr. E. Carlyle Clark, Heathsville, Virginia | |
| 18. 412.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Cardiac Decompensation
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerotic Cardio-vascular Disease
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
2 yrs. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 19 68 to June 1 19 69 , that (I) (we) last saw the deceased alive on June 1 19 69 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Clarence W. LeDoux | | 23B. DATE SIGNED
6/2/69 | | 23C. PHYSICIAN'S NAME (Type) Dr. Clarence W. LeDoux | |
| 23D. ADDRESS
3023 Eastern Avenue | | 23E. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-4-1969 | | 24C. NAME OF CEMETERY or CREMATORY
Lebanon Baptist Church Cem. | |
| 24D. LOCATION (City, town, or county)
Alfonso, Virginia | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Howard H. Hubbard | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard | |

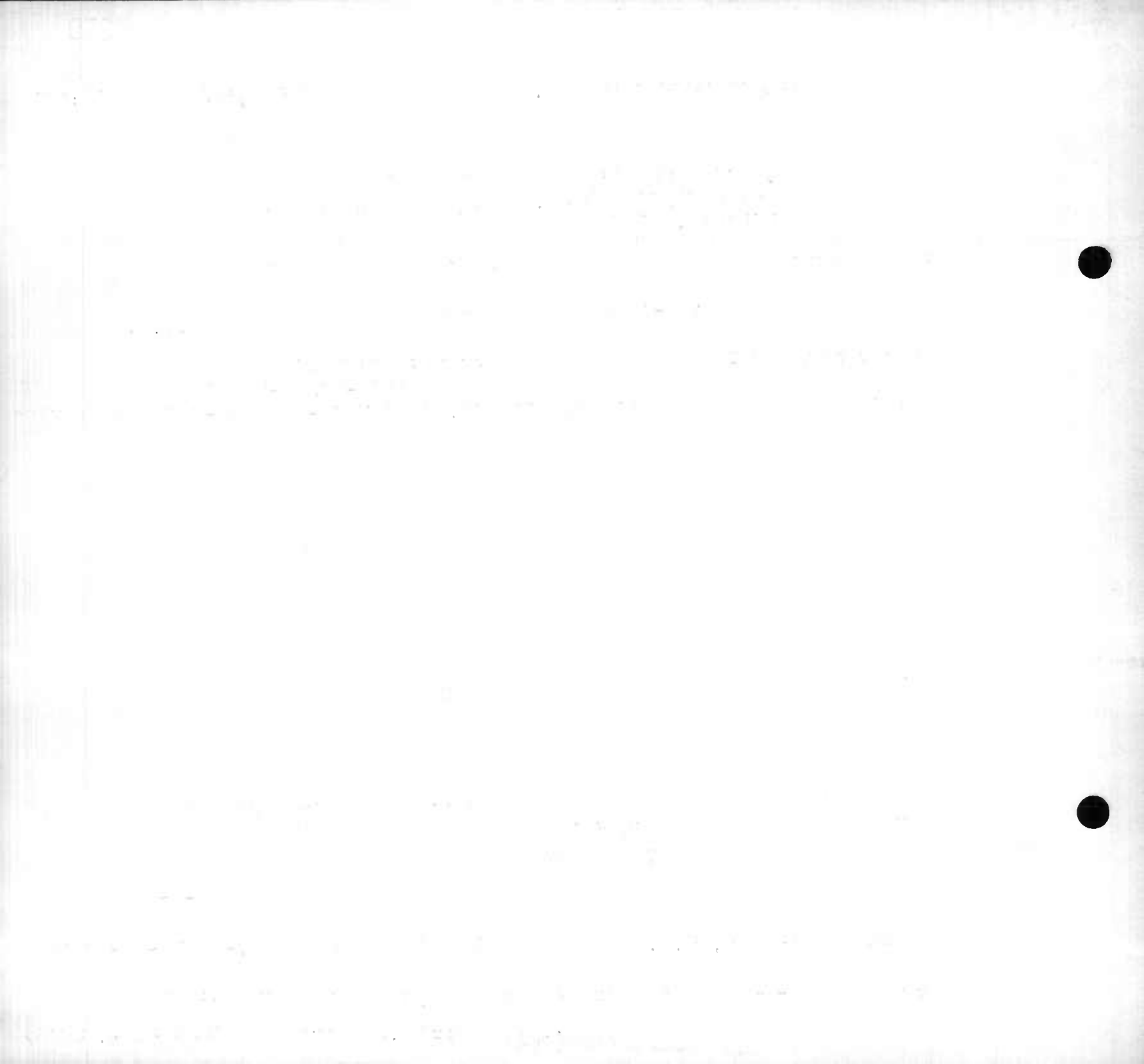


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5659 CERTIFICATE OF DEATH

REG. NO. 69 5659

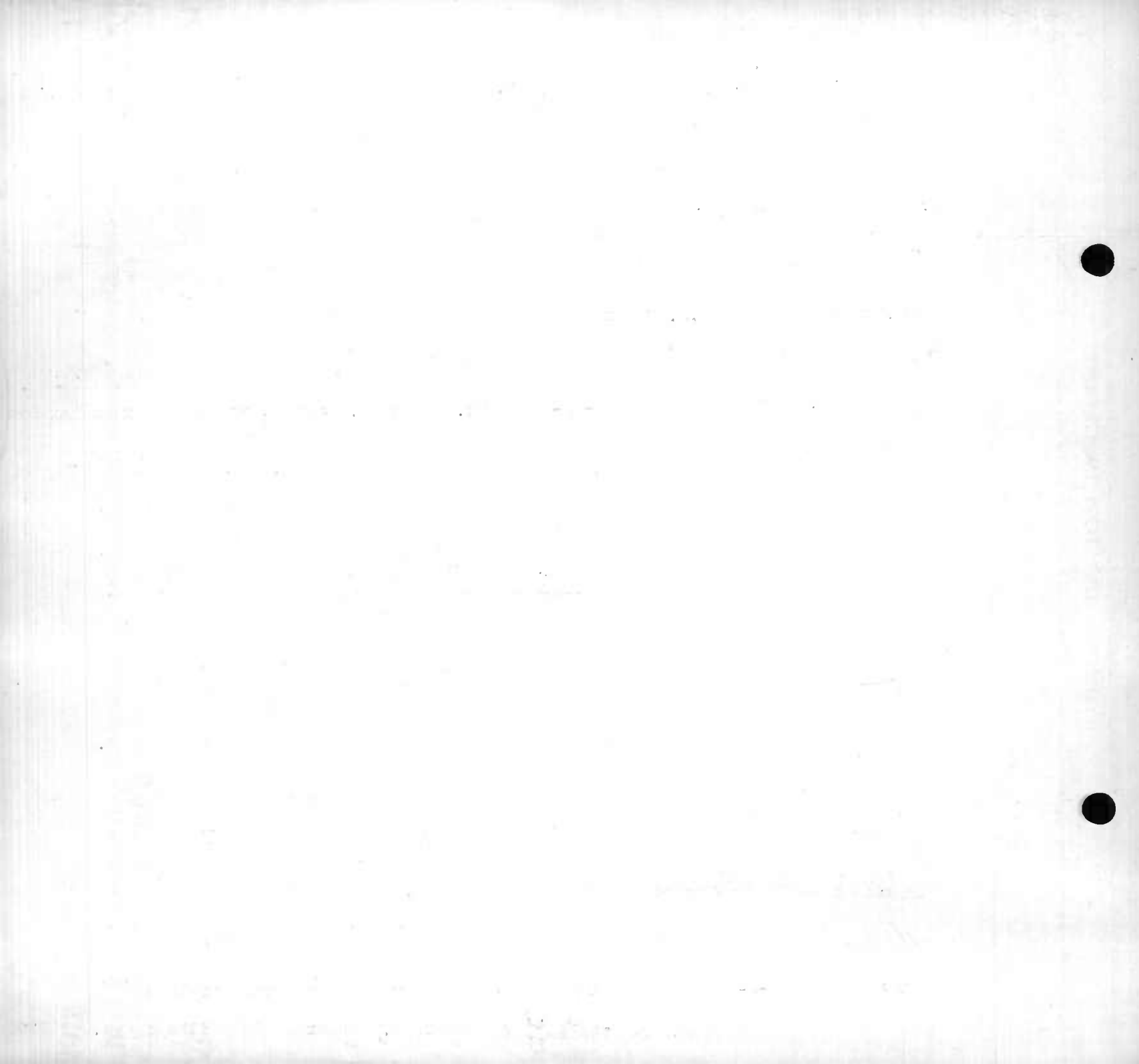
| | | | | | |
|--|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | ROBERT HUGH GRIM, SR. | | JUNE 1, 1969 11:25AM. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 ST. AGNES HOSPITAL
CATON & WILKENS AVES.
BALTIMORE, MARYLAND 21229 | | | | MARYLAND Baltimore 21229 53-00 | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| MALE | | WHITE | | 8. DATE OF BIRTH
02 11 06 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | |
| Machinist | | Tate-Temco | | 63 | |
| 13. FATHER'S NAME | | | | 11. BIRTHPLACE (State or foreign country) | |
| HENRY TUCKER GRIM | | | | MARYLAND | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | | 14. MOTHER'S MAIDEN NAME | |
| YES WW2 | | | | ESTELLE (CATHER) | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT AVE-BALTO-MD 21229 ADDRESS | |
| 212 09 8138 | | | | ST. AGNES HOSP-RECORDS-CATON & WILKENS | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
431.9 I Cerebral
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLINO OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from MAY 31 19 69 to JUNE 1 19 69 that (X) (we) last saw the deceased alive on JUNE 1 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Adolfo Alonso | | | | 23B. DATE SIGNED
6-1-69 | |
| 23C. PHYSICIAN'S NAME (Type)
ADOLFO ALONSO, M.D. | | | | 23D. ADDRESS
CATON & WILKENS AVES.-BALTO-MD-21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 6-5-1969 | | Baltimore National Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 3 1969 | | Robert E. Taylor, M.D. | | Howard H. Hubbard | |
| | | | | ADDRESS
4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5660 | |
|---|--|--|--|---|--|
| BIRTH NO. 69 5660 | | 1. NAME OF DECEASED
(Type or Print) <u>WALTEMEYER</u>
<u>Ellison Waltemeyer, Sr.</u> | | 2. DATE AND HOUR OF DEATH
<u>June 2, 1969</u> <u>6:20 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>11-02</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>48</u>
<u>Maryland General Hospital</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>m</u> 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH <u>5/12/05</u> 9. AGE (In years lost birthday) <u>64</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Pier Foreman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Government</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME
<u>Herbert Waltemeyer</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lillian Rider</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> <u>W W II.</u> | | 16. SOCIAL SECURITY NO.
<u>705-05-5419</u> | | 17. INFORMANT ADDRESS <u>21207</u>
<u>Mr. Robert M. Waltemeyer, 1110 Dorchester Ave</u> | |
| 18. <u>5210 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
<u>Pneumonia</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Delirium Tremens</u>
<u>Chronic Fatty Metamorphosis of Liver</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>> 48 hours</u>
<u>< 24 hours</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>2-</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/31/69</u> to <u>6/2/69</u> , that (I) (we) last saw the deceased alive on <u>6/2/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>William L. Boddie, M.D.</u>
DEGREE | | | | 23B. DATE SIGNED
<u>6-2-69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>William L. Boddie</u>
DEGREE | | | | 23D. ADDRESS
<u>Maryland General Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6-5-1969</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Baltimore National Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Howard H. Hubbard</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> | | | |



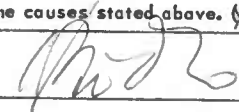
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69

5661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5661

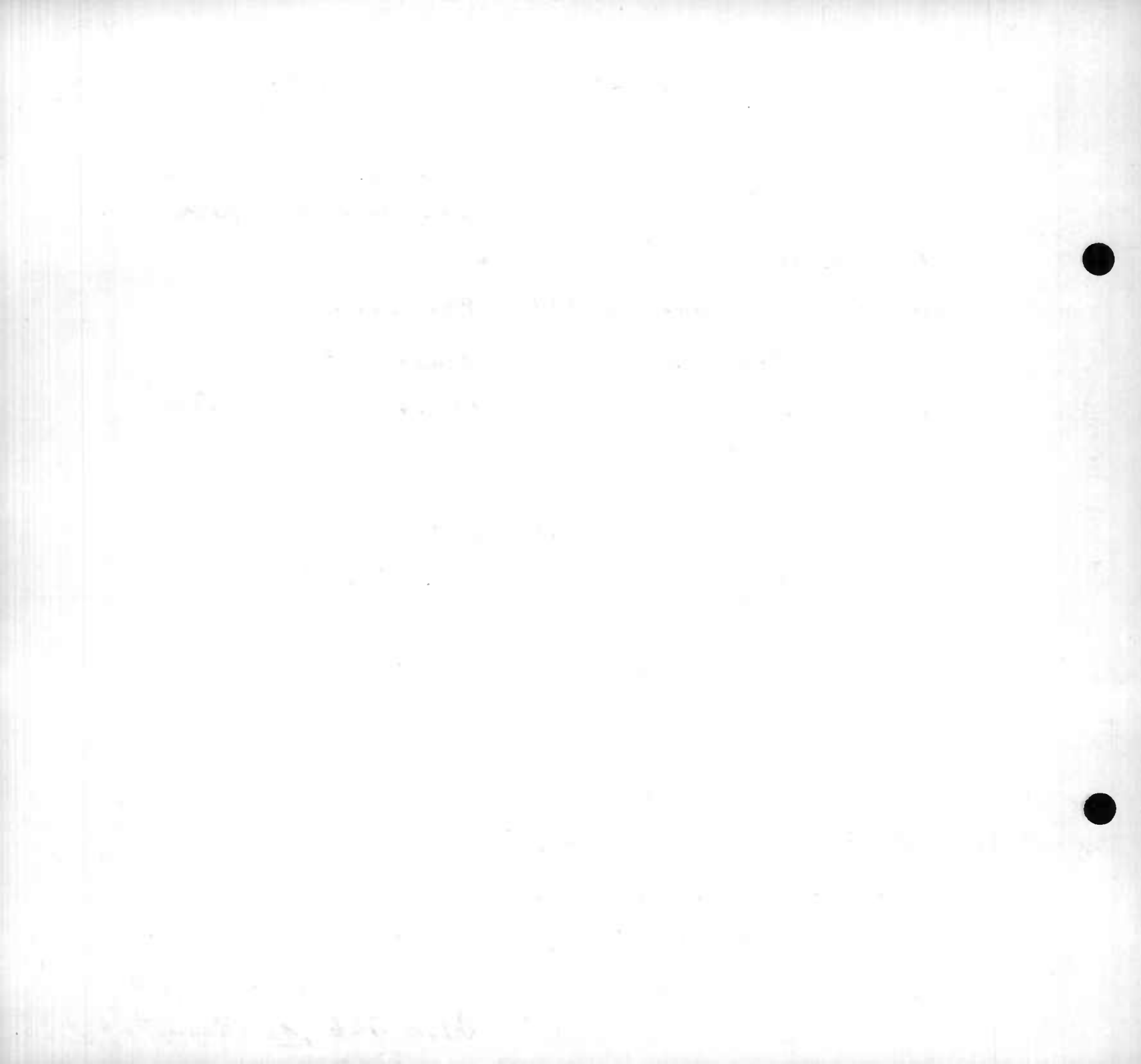
| | | | | | |
|---|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) PIPES, LOUELLA | | 2. DATE AND HOUR OF DEATH
MAY 31, 1969 9:30A | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY HOWARD CO. | | C. CITY OR TOWN ELLICOTT CITY | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST. AGNES HOSPITAL
CATON & WILKENS AVES.
BALTIMORE, MARYLAND 21229 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 12 20 1911 | | 9. AGE (in years last birthday) 57 79 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JAMES POFF | | 14. MOTHER'S MAIDEN NAME MINNIE (MACNEAL) | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 251 22 9268 | | 17. INFORMANT WILKENS AVES.-BALTO MD. 21229
ST. AGNES HOSPITAL RECORDS-CATON & | |
| 18. CAUSE OF DEATH
43391
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (A) IMMEDIATE CAUSE Cerebral Aneurysm
DUE TO, OR AS A CONSEQUENCE OF:
Cerebral Thrombosis
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from MAY 24 19 69 to MAY 31 19 69 that (X) (we) last saw the deceased alive on MAY 31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | 23B. DATE SIGNED MAY 31, 1969 | | 23C. PHYSICIAN'S NAME (Type) HERMENEGILDO ISIDRO MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 6/3/69 | | 24C. NAME OF CEMETERY OR CREMATORY Crestlawn | |
| 24D. LOCATION (City, town, or county) (State) Ellicott City, Howard, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JUN 3 1969 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Higinbotham Slack | | 25D. ADDRESS Ellicott City, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5662 | |
|---|-------------------------|--|---|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) JOHN FRANK VENA VAGE | | 2. DATE AND HOUR OF DEATH
JUNE 1, 1969 9^{PM} M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY 25-05 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
43 S.B.C. Hosp. | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTIMORE | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
1523 Church ST. Balto 21226 | |
| 5. SEX
M | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MAY 19, 1907 | 9. AGE (In years last birthday)
62 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
American Oil Co | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
John VENA VAGE | | 14. MOTHER'S MAIDEN NAME
MARY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Family ADDRESS
Same | |
| 18. 571.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE C.V.A.
DUE TO, OR AS A CONSEQUENCE OF:
(B) ASCVD HD
DUE TO, OR AS A CONSEQUENCE OF:
(C) Laemee Unborn | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1965 to 1 May 1969 , that (I) (we) last saw the deceased alive on 1 May 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Andrew R. Sosnowski OEGREE | | | | 23B. DATE SIGNED
6/2/69 | |
| 23C. PHYSICIAN'S NAME (Type)
Andrew R. Sosnowski OEGREE | | | | 23D. ADDRESS
4016 Ritchie Hwy Balto 25 MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-5-69 | | 24C. NAME OF CEMETERY or CREMATORY
Holt Cross Com. | |
| 24D. LOCATION
Balto 21225 MD | | 24E. (City, town, or county) | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
George E. Taylor, MD. | | 25C. FUNERAL DIRECTOR
John W. Gahan, 4200 Pennington Ave 21226 | |
| 25D. ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 5663

| | | | | | |
|---|--|---|--|---|--|
| BIRTH NO. <u>69 5663</u> | | 1. NAME OF DECEASED
(Type or Print) <u>Carolyn B Albers</u> | | 2. DATE AND HOUR OF DEATH
<u>6-1-69</u> <u>3:35</u> P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md</u> B. COUNTY <u>city</u> | | C. CITY OR TOWN <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Maryland General Hospital</u>
<u>48</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>F</u> | | 6. RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>At Home</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>6-6-93</u> 9. AGE (In years last birthday) <u>75</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Carl Boudsein</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Louise Bersch</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>215-18-2126</u> | |
| 17. INFORMANT <u>Erichant Albers</u> | | ADDRESS | | | |
| 18. <u>1819 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Metastatic Carcinoma of stomach</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>5-31</u> 19 <u>69</u> to <u>6-1</u> 19 <u>69</u> that (I) <u>(we)</u> last saw the deceased alive on <u>6-1</u> 19 <u>69</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>James J. Humby M.D.</u> | | 23B. DATE SIGNED
<u>6-1-69</u> | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS | | 23E. DEGREE | | 23F. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6-5-69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cemetery - Balto. Md</u> | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR
<u>1969</u> | |
| 24G. FUNERAL DIRECTOR
<u>Armacost Funeral Chapel - 4600 Lib Heights Ave</u> | | 24H. ADDRESS | | 24I. DATE | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 5664 CERTIFICATE OF DEATH

REG. NO. 69 5664

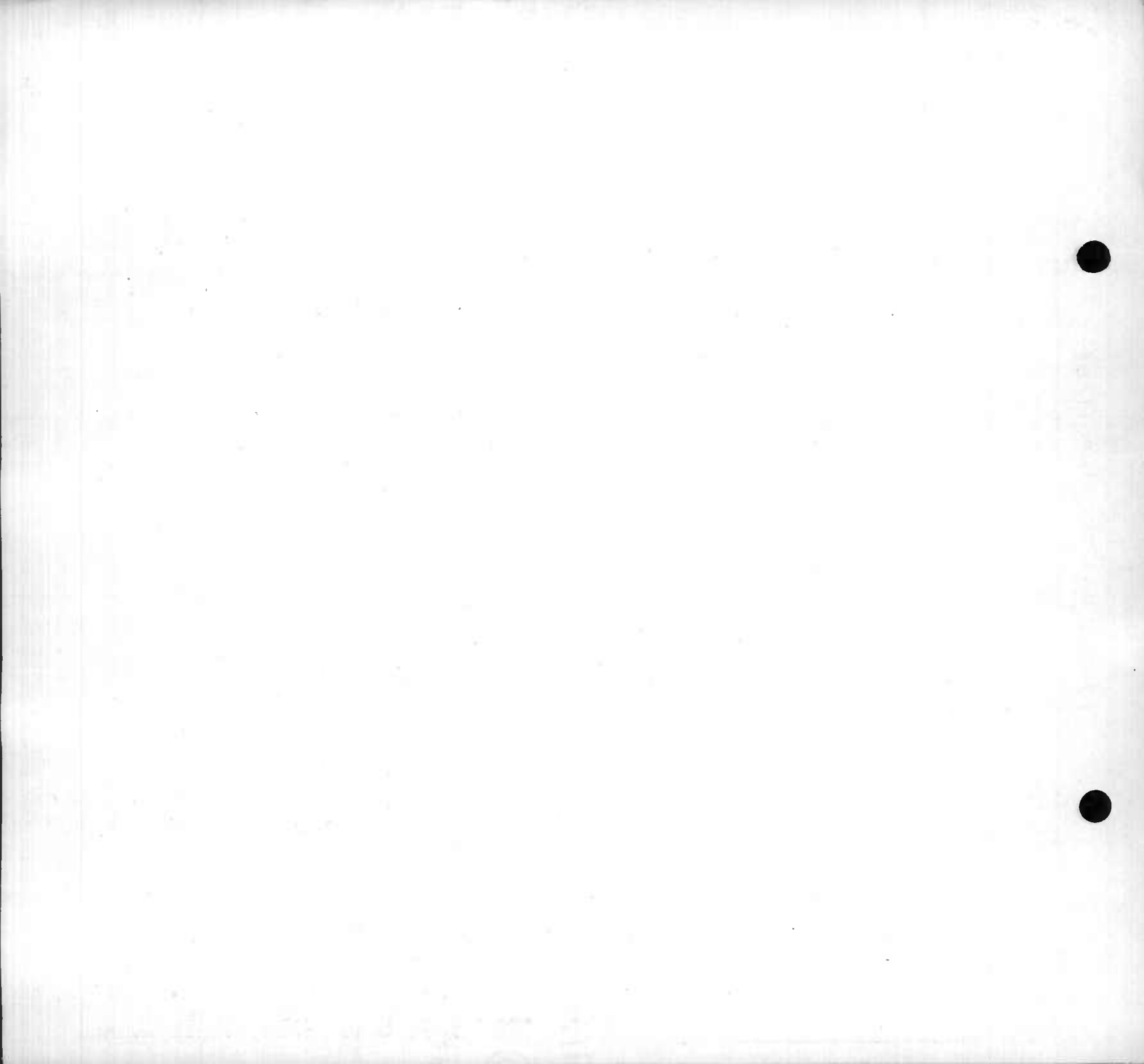
| | | | |
|--|----------------|---|--|
| BIRTH NO. | | 69 5664 | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| ROTE, JOHN H. | | 6/1/69 10:45 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
42 SINAI HOSPITAL | | A. STATE
Md
B. COUNTY
28-41 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTIMORE | |
| | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
3827 Ferndale Ave. | |
| 5. SEX
M | 6. RACE
Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/8/03 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PLANTER | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
65 |
| 13. FATHER'S NAME
Silas H. Rote | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
416-01-3060 | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 17. INFORMANT
Eva S Rote - Same | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
D. 4/18/9 I
This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
MYOCARDIAL INFARCTION
(B) ASCVD
(C) PNEUMONIA | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTES
5 YEARS
DAYS | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 5/29/69 (year) to 6/1/69 19 that (X) (we) last saw the deceased alive on 6/1/69 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Eric Judely | | 23B. DATE SIGNED
6/1/69 | |
| 23C. PHYSICIAN'S NAME (Type)
ERIC JUDITZ | | 23D. ADDRESS
SINAI HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-4-69 | |
| 24C. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
James E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
A. M. B. C. Funeral Chapel - 4601 Liberty Ave | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 5665 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5665 | |
|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) Louis HERMAN | | | | 2. DATE AND HOUR OF DEATH
6-1-69 8:45 AM. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

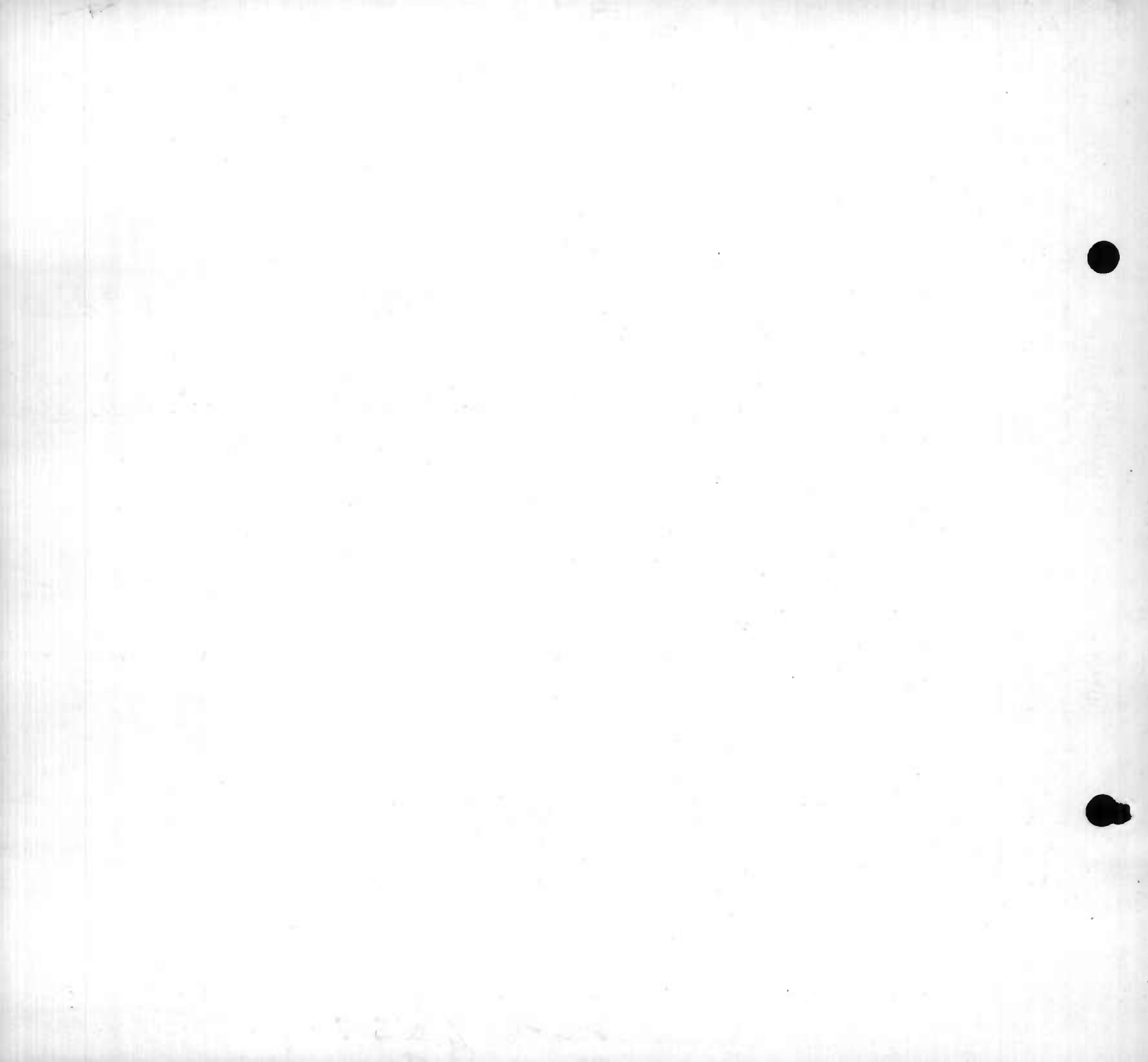
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Sinai Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY 27-19 | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-6-00 | |
| 9. AGE (In years last birthday) 68 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Industrial Foreman | | 11. BIRTHPLACE (State or foreign country)
Austria | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Leiser Herman | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
081-09-6535 | | 17. INFORMANT
Kingsway Mem. Chapel, N.Y. | |
| 18. 203 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Multiple Myeloma | | | | 19. CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Multiple Myeloma 1 yr. | | ADDRESS 1978 Conyngham Ave
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 21G. DATE SIGNED
6-1-69 | | 21H. SIGNATURE
GERALD B. Feldman, MD | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/6 19 69 to 6/1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | 23A. SIGNATURE
GERALD B. Feldman, MD | | 23B. DATE SIGNED
6-1-69 | |
| 23C. PHYSICIAN'S NAME (Type)
GERALD B. Feldman, MD | | 23D. ADDRESS
Sinai Hospital | | 23E. NAME OF REGISTRAR
Wm. J. Ticker & Sons | | 23F. FUNERAL DIRECTOR ADDRESS
North and Pennsylvania Avenue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
6/3/69 | | 24B. DATE
6/3/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Beth David Cem | | 24D. LOCATION (City, town, or county) (State)
Elmont Long Island N.Y. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Wm. J. Ticker & Sons | | 25C. FUNERAL DIRECTOR
Wm. J. Ticker & Sons | | 25D. ADDRESS
North and Pennsylvania Avenue | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

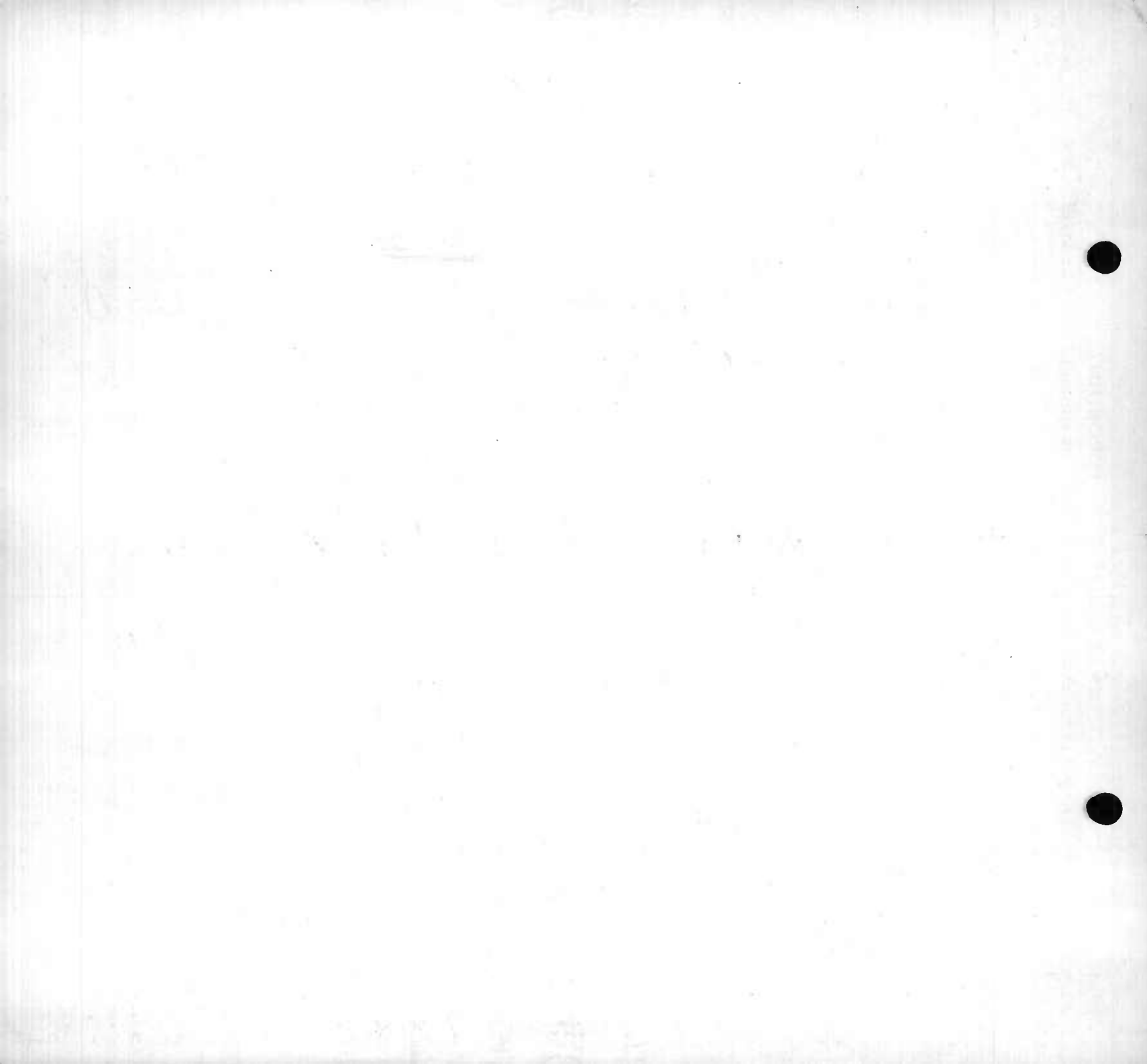
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5666 | |
|--|----------------------|--|---|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) KATHERINE CALVERT | | 2. DATE AND HOUR OF DEATH
6/1/69 10:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY Balt. City C. CITY OR TOWN Golden Gate D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Harbor View C & N. Home | | | E. STREET AND NUMBER
1212 Light Street | | |
| 5. SEX
F | 6. RACE
W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> S/P DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
9/10/10 | 9. AGE (In years last birthday)
58 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MD | |
| 12. CITIZEN OF WHAT COUNTRY?
USA. | | | 13. FATHER'S NAME
Edward Day | | |
| 14. MOTHER'S MAIDEN NAME
Clara Kieffer | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
Mrs Mary Stecker ADDRESS 71122 706 Helton Rd | | |
| 18. 71231
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)
Rheumatoid Arthritis | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
gms. | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 6/1/69 to 6/1/69 , that (2) (we) lost saw the deceased alive on 6/1/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A.C. Alevizatos, M.D. | | | 23B. DATE SIGNED
6/1/69 | | 23C. PHYSICIAN'S NAME (Type)
A.C. ALEVIZATOS, M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | 24B. DATE
7/4/69 | | 24C. NAME OF CEMETERY or CREMATORY
ELLEN HAVEN CEM |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MD | | | 24E. FUNERAL DIRECTOR
1209 St. Paul St | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | 25B. NAME OF REGISTRAR
1209 St. Paul St | | |
| 25C. FUNERAL DIRECTOR
1209 St. Paul St | | | 25D. ADDRESS
1209 St. Paul St | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 69 5667 | |
|---|-------------------------|---|---|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Sister Mary Consilia DeFiore</i> | | 2. DATE AND HOUR OF DEATH
<i>5-28-69 1:00 A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>34 Bon Secours Hospital</i> | | | A. STATE <i>Maryland</i>
B. COUNTY <i>25-62</i> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<i>1201 CATON Ave.</i> | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>WHITE</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>AT 5-20-1920</i> | 9. AGE (In years last birthday)
<i>49</i> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>TEACHER</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>EDUCATION</i> | | 11. BIRTHPLACE (State or foreign country)
<i>New York</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>Julius DeFiore</i> | | 14. MOTHER'S MAIDEN NAME
<i>Consilia Mascolo</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | 16. SOCIAL SECURITY NO.
<i>800-01-0485</i> | | 17. INFORMANT
<i>Phys. CHART</i> | |
| 18. <i>183.01</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>Metastatic carcinoma of ovary.</i> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Metastatic carcinoma of ovary.</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Mos.</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5-10-1969</i> to <i>5-28-1969</i> , that (I) (we) last saw the deceased alive on <i>5-28-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Chaweng Ongkasuwan M.D.</i> | | | | 23B. DATE SIGNED
<i>5-28-69</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>CHAWENG ONGKASUWAN, M.D.</i> | | | | 23D. ADDRESS
<i>Bon Secours Hospital.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>5-31-69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>MADONNA CEMETERY</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>FORT LEE, NEW JERSEY</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 3 1969</i> | | 25B. NAME OF REGISTRAR
<i>Wm E. Taber, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>RAYMOND J. CURRAN</i> | |
| | | | | ADDRESS
<i>517 SCARLETT DR TOWSON, MD 21204</i> | |



B-650

69 5668 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5668

REG. NO.

BIRTH NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
SUSAN BROWN | | | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
5 31 1969 6:22 p.m. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 1440 Winston Ave. | | | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 31 1969 6:22 p.m. | | | |
| 6. SEX
Female | | | | 7. RACE
White | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
8/17/1914 | | | | 10. AGE (In years lost birthday)
54 | | 11. BIRTHPLACE (State or foreign country)
Jerome, Pennsylvania | |
| 12. CITIZEN OF
U.S.A. | | | | 13. FATHER'S NAME
George Yacos | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waitress | | | | 15. MOTHER'S MAIDEN NAME
Ann Olenick | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | | | 17. SOCIAL SECURITY NO.
212-07-7891 | | 18. INFORMANT ADDRESS
Edward Brown As Above | |
| 19. CAUSE OF DEATH
571.8 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Fatty liver
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF:
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 20A. DATE OF OPERATION
2 | | | | | | | |
| 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Partial | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson, M.D. M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED June 1, 1969 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/5/1969 | | 24C. NAME OF CEMETERY or CREMATORY
Chapel Hill Cemetery | | 24D. LOCATION (City, town, or county) (State)
Weirton, West Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Raymond C. Fink | | ADDRESS
Glen Burnie, Md. | |

8/17/1914

Jerome, Pennsylvania U. S. A.

Witness Restaurant Ann Clerk

No. 212-07-7891 Edward Brown as above

Burial 6/25/1909 Chapel Hill Cemetery Weston, West Virginia
Raymond C. Rank Glen Burnie, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5669 | |
|---|---------------------|---|-----------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Vick, Paul</u> | | 2. DATE AND HOUR OF DEATH
<u>5/31/69 @ 9pm</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>South Baltimore General Hospital</u>
<u>43</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <u>Maryland</u>
B. COUNTY <u>21-02</u> | |
| | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>1128 W. Cross Street</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-9-00</u> | 9. AGE (in years last birthday)
<u>69</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Coin Machine Oper.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>1st National Bank</u> | | 11. BIRTHPLACE (State or foreign country)
<u>North Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | 13. FATHER'S NAME
<u>? Durwood Vick</u> | | 14. MOTHER'S MAIDEN NAME
<u>?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>241-16-3510</u> | | 17. INFORMANT
<u>Chart Elizetta Vick</u> ADDRESS <u>1128 W. Cross St</u> | |
| 18. <u>436.9 I</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>Cerebrovascular Accident</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 weeks</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>pneumonia, isolated</u> | | <u>4 weeks</u> | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/31/69</u> to <u>5/31/69</u> that (I) (we) last saw the deceased alive on <u>5/31/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Sang Y. Rhim, MD</u> | | | | 23B. DATE SIGNED
<u>5/31/69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>SANG YOIN RHIM</u> | | 23D. ADDRESS
<u>South Baltimore General Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/4/69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Western Cemetery</u> | |
| 24D. LOCATION
<u>Edmondson Ave. Balto. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
<u>96900</u> | |
| 25C. FUNERAL DIRECTOR
<u>Schweinsberg Funeral Service</u> | | 25D. ADDRESS
<u>126 W. Cross St.</u> | | | |

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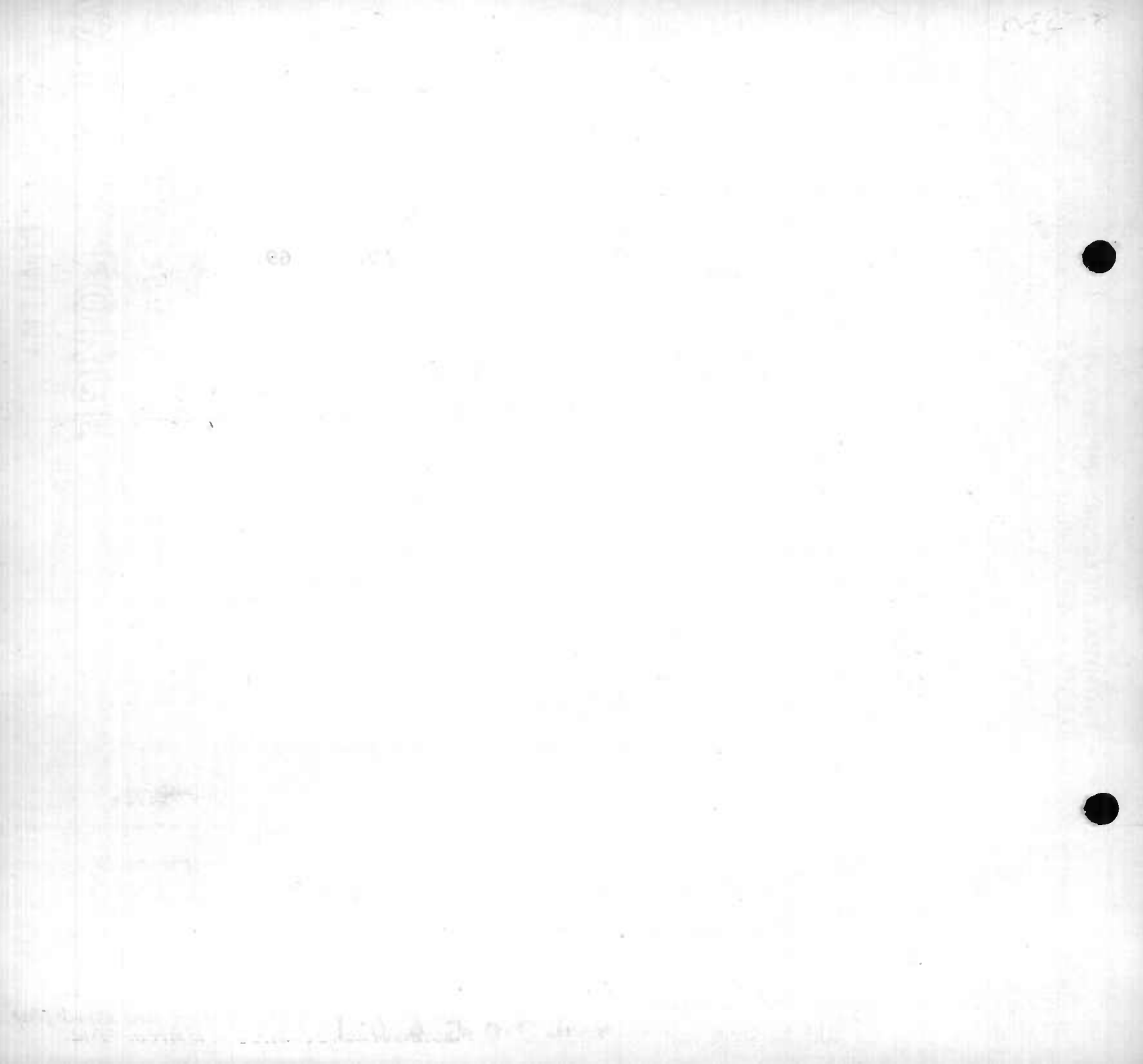
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 69 5670 |
|---|-----------|---|---|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Catherine A. Smith
CATHERINE A. SMITH | | 2. DATE AND HOUR OF DEATH
May 30 1969 8:30 pm M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
4 UNION MEMORIAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MD. B. COUNTY 13-48
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 34 55 ASH ST. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/23/1900 | 9. AGE (In years lost birthday) 69 (69) | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE - HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
american |
| 13. FATHER'S NAME
- WILLIAM BROWN | | | 14. MOTHER'S MAIDEN NAME
MATTIE HAINES | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
NONE | 17. INFORMANT ADDRESS
MARGARET BLUNT 4605 Ashbury Ave Balto, Md. | | |
| 18. CAUSE OF DEATH
2509 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
19A. DATE OF OPERATION 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED
While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 5/30/69 19 to 5/30/69 19
that (I) (we) last saw the deceased alive on 5/30/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.
23A. SIGNATURE
Cesar A Bravo M.D. DEGREE
23B. DATE SIGNED
5/30/69
23C. PHYSICIAN'S NAME (Type)
CESAR A BRAVO DEGREE
23D. ADDRESS
UNION MEMORIAL HOSPITAL
24A. BURIAL CREMATION, REMOVAL (Specify)
Burial
24B. DATE
6/3/69
24C. NAME of CEMETERY or CREMATORY
GLEN HAVEN Cem.
24D. LOCATION (City, town, or county) (State)
A.A. Co. Md.
25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969
25B. NAME OF REGISTRAR
Robert G. Altenburg
25C. FUNERAL DIRECTOR
Funeral Home, Inc. Balto, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 69 5671 |
|---|-------------------------------------|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> 4-4201 69 5671 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO.
1. NAME OF DECEASED
(Type or Print) Zenobia Jones Hollis | | | 2. DATE AND HOUR OF DEATH
June 2, 1969 12:30 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

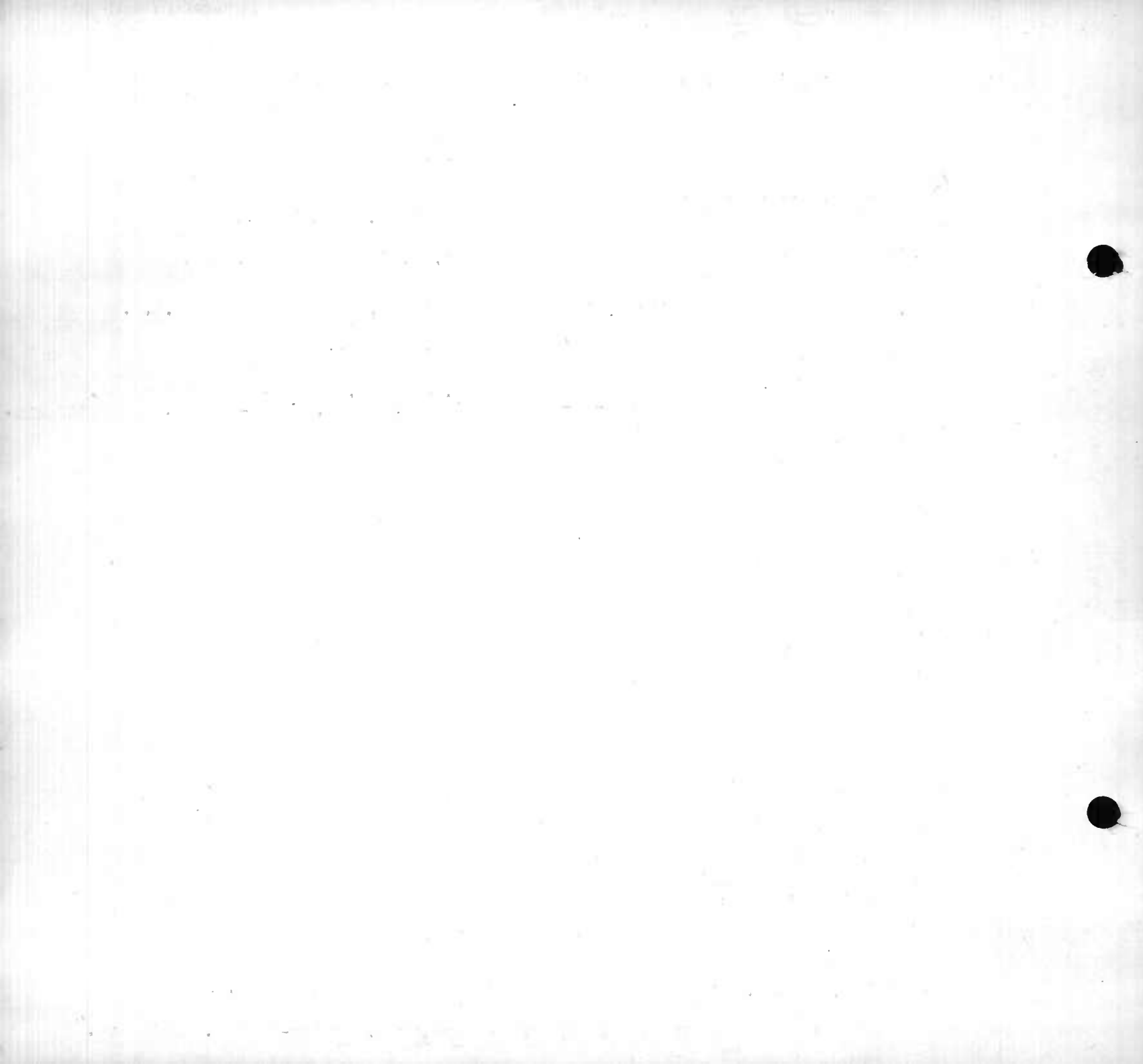
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
90 1410 McCulloh Street | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY 15-04
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER
1918 N. Bentalou Street | | |
| 5. SEX
Female | 6. RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 7, 1884 | 9. AGE (In years last birthday)
84 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Teacher | | 10B. KIND OF BUSINESS OR INDUSTRY
Public School | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Edward Jones | | | 14. MOTHER'S MAIDEN NAME
Annie Carwell | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-48-0183 | 17. INFORMANT ADDRESS
Mrs. Ethel J. Hucles-3506 Denison Rd.
Miss Laura W. Jones-1009 W. Lafayette Ave. | | |
| 18. CAUSE OF DEATH
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> (A) IMMEDIATE CAUSE <i>Myocardial Degeneration</i>
 DUE TO, OR AS A CONSEQUENCE OF:

 (B) Hypertensive Cardio Vascular
 DUE TO, OR AS A CONSEQUENCE OF:

 (C) Diarrhea </div> <div style="width: 10%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
 <i>3 1/2</i>

 <i>1 yr</i> </div> </div> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5/20/69</i> 19 to <i>6/2/69</i> 19
that (I) (we) last saw the deceased alive on <i>6/2/69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Samuel DeLoach M.D.</i> | | | | 23B. DATE SIGNED
<i>6/3/69</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>G. Franklin Phillips M.D.</i> | | | | 23D. ADDRESS
<i>558 McCulloh St. Balt. Md.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
6/5/1969 | 24C. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | 24D. LOCATION (City, town, or county) (State)
Baltimore Co. Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS
Herbert E. Nutter-3035 W. North Ave. | |

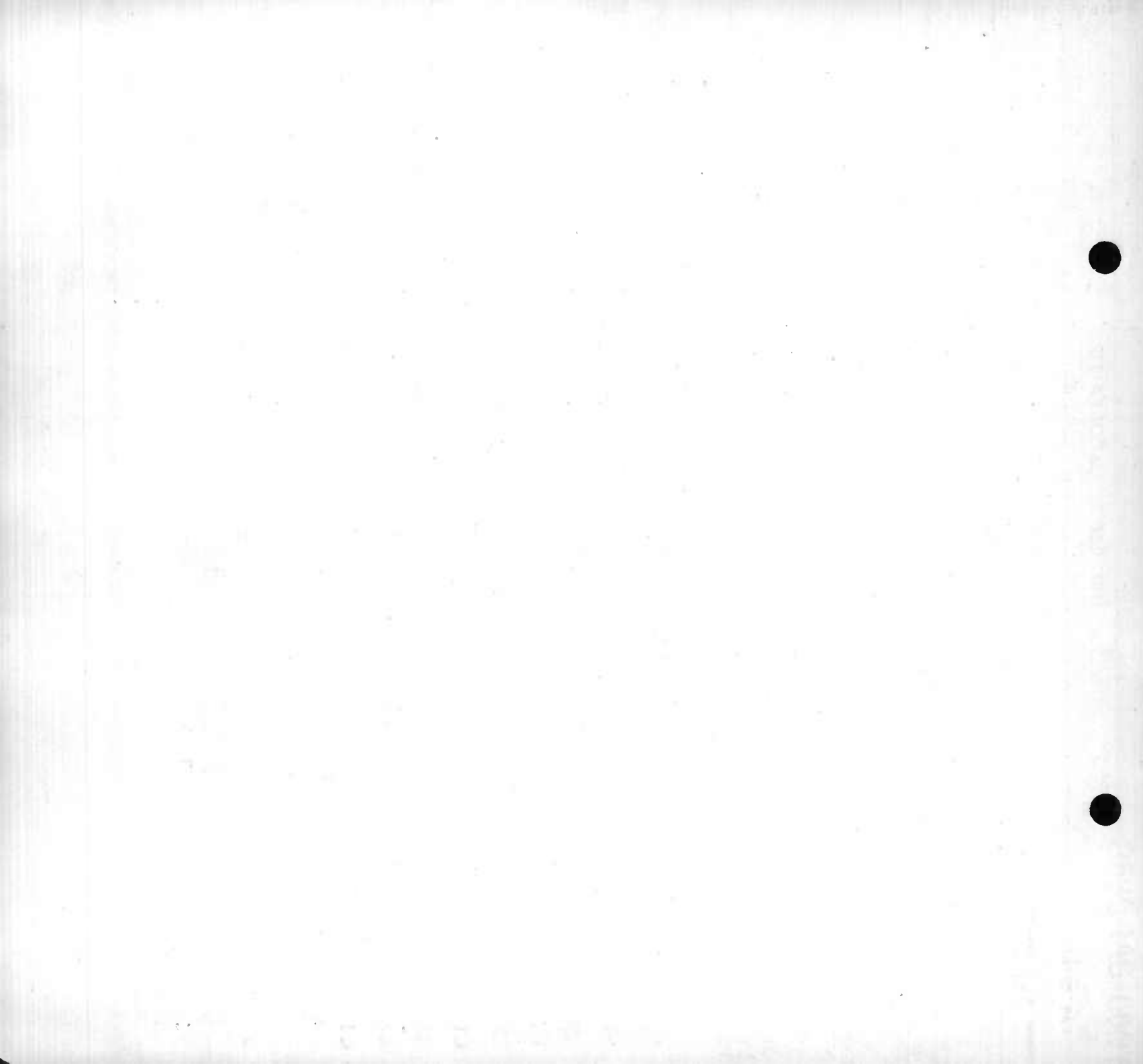


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) Lockard Vernon, T. | | | | 2. DATE AND HOUR OF DEATH
6/3/69 | | | | 1:35 AM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

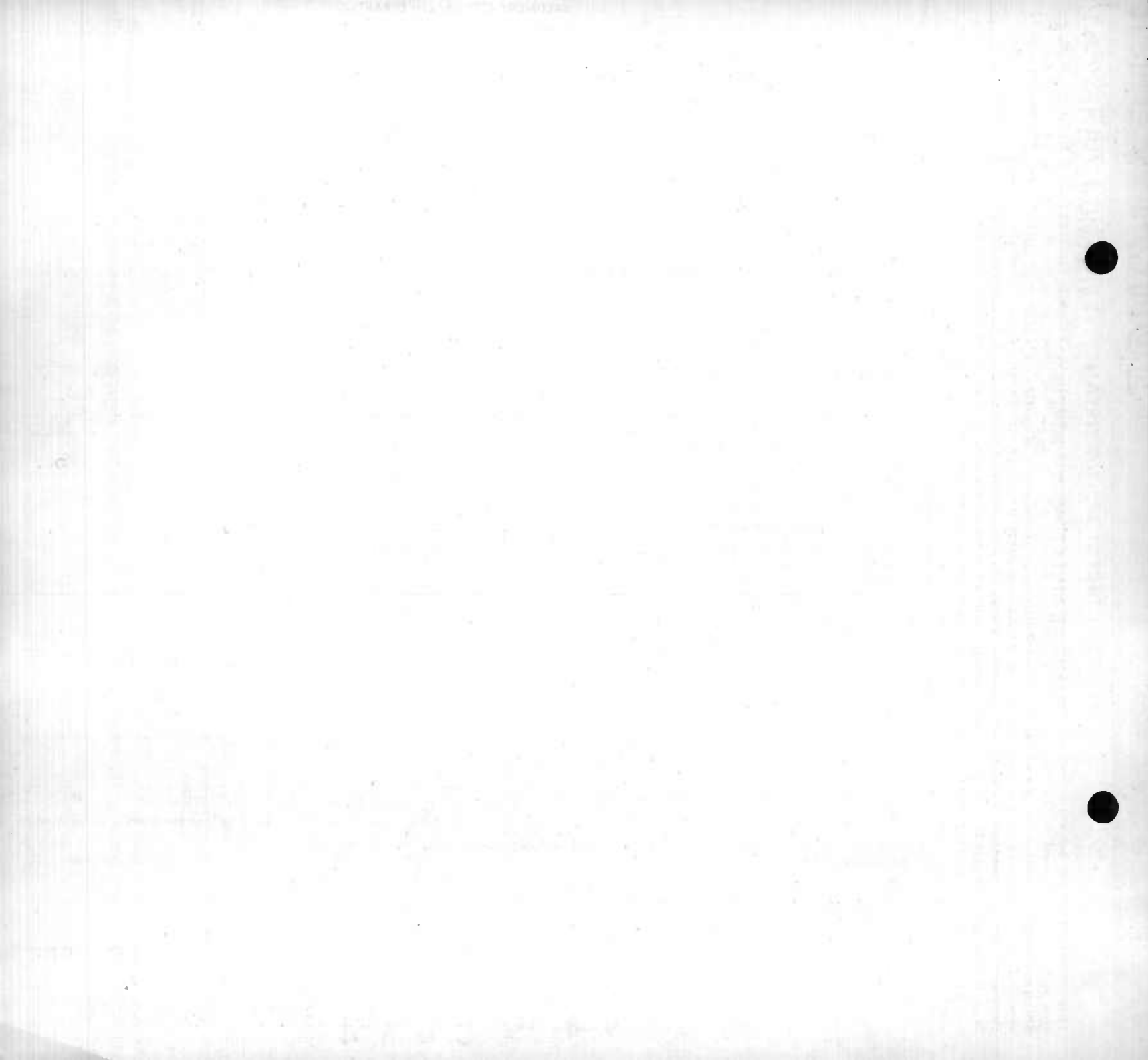
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Bon Secours Hospital
Baltimore, Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore | | | | 19-03 | | | |
| 5. SEX M | | | | 6. RACE W | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH 1/24/01 | | | | 9. AGE (In years last birthday) 68 | | | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Pipe Cutter | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
Milton C. Lockard | | | | 14. MOTHER'S MAIDEN NAME
Edna J. Miller | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
217-05-3808 | | | | 17. INFORMANT ADDRESS
Hospital Records --Bon Secour | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Chronic congestive heart failure | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Bronchopneumonia | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Fracture of left hip | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
Fracture of left hip | | | | 9 wks | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18
II | | | | | | | | | | | |
| 19A. DATE OF OPERATION
3/27-69 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Fracture of left hip | | | | 20A. AUTOPSY? (Yes or No)
No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
street | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
51 South Wm. street | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
3 / 21 / 69 6pm | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR?
walking on the street | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/21 1969 to 6-3 1969 , that (I) (we) last saw the deceased alive on 6/3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
M. Achum | | | | 23B. DATE SIGNED
6/3/69 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
DANIELINO F. ARBUERNE | | | | 23D. ADDRESS
Bon Secours Hospital | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
6/5/69 | | | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park | | | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | | 25B. NAME OF REGISTRAR
John E. Staley, M.D. | | | |
| 25C. FUNERAL DIRECTOR ADDRESS
Witzke, 4101 Edmondson Ave., 21229 | | | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 69 5673 | |
|--|---------|--|---|--|--|
| BIRTH NO. | | 69 5673 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | ALSO KNOWN AS MANUEL JOHN BARKINS | | DATE AND HOUR OF DEATH | |
| Dr. John Manuel Bradford | | | | June 1, 1969 9:55 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| US Public Health Service Hospital
3100 Wyman Parkway | | | Md. 28-34 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 826 Glen Allen Drive | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| M | W | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 2/15/13 | 56 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Physician | | | | NJ | |
| 12. CITIZEN OF WHAT COUNTRY? | | | USA | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| John Bradford (Barkins) | | | Bell (?) last name | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No | | | 109-36-3662 | | Records- US PHS Hospital, Balto, Md. |
| 18. CAUSE OF DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| I | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE | | | | | Cerebral metastases 2 mos. |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (B) Adenocarcinoma of the colon 3 yrs. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | Pulmonary & skeletal metastases 2 mos. |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Apr. 25 1969 to June 1 1969, that (1) (we) last saw the deceased alive on June 1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Peter H. Rheinheim, MD | | | | 6/2/69 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Peter H. Rheinheim, Surgeon (R) | | US PHS Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | June 3, 1969 | | Crestlawn | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Marriottsville Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 3 1969 | | John E. Feltz, R.D. | | Howard County Funeral Home of Harry Witzke | |
| | | | | 25D. ADDRESS | |
| | | | | Ellicott City Maryland | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|------------------------------|---|---|
| 69 5674 | | BALTIMORE CITY HEALTH DEPARTMENT | | 69 5674 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| TILLMAN, LILLIAN MAE | | JUNE 2, 1969 | | 2:30P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

40 ST. AGNES HOSPITAL | | A. STATE
MARYLAND | | B. COUNTY
BALTIMORE | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER
5637 ASHBURN RD 21227 | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
02/16/82 | 9. AGE (In years last birthday)
87 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
GEORGE TAYLOR | | 14. MOTHER'S MAIDEN NAME
BARBARA (NEE DISENROTH) | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NONE | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
ST. AGNES HOSPITAL RECORDS | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. | | CAUSE OF DEATH
CVA.
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
A.S.E.D.
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Chronic Brain Syndrome | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 30 1969 to JUNE 2 1969 | | that (I) (we) lost saw the deceased alive on JUNE 2 1969 and that (in my) (our) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>Alexandro Mejia</i> | | 23B. DATE SIGNED
6/2/69 | | | |
| 23C. PHYSICIAN'S NAME (Type)
ALEXANDRO MEJIA MD | | 23D. ADDRESS
BALTO, MD 21229
ST. AGNES HOSP; CATON & WILKENS AVES. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
6/5/69 | 24C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | 25B. NAME OF REGISTRAR
C. E. J. B. MD | 25C. FUNERAL DIRECTOR
A. B. S. L. MD | | ADDRESS
1328 Sulphur Sp. Rd. | |

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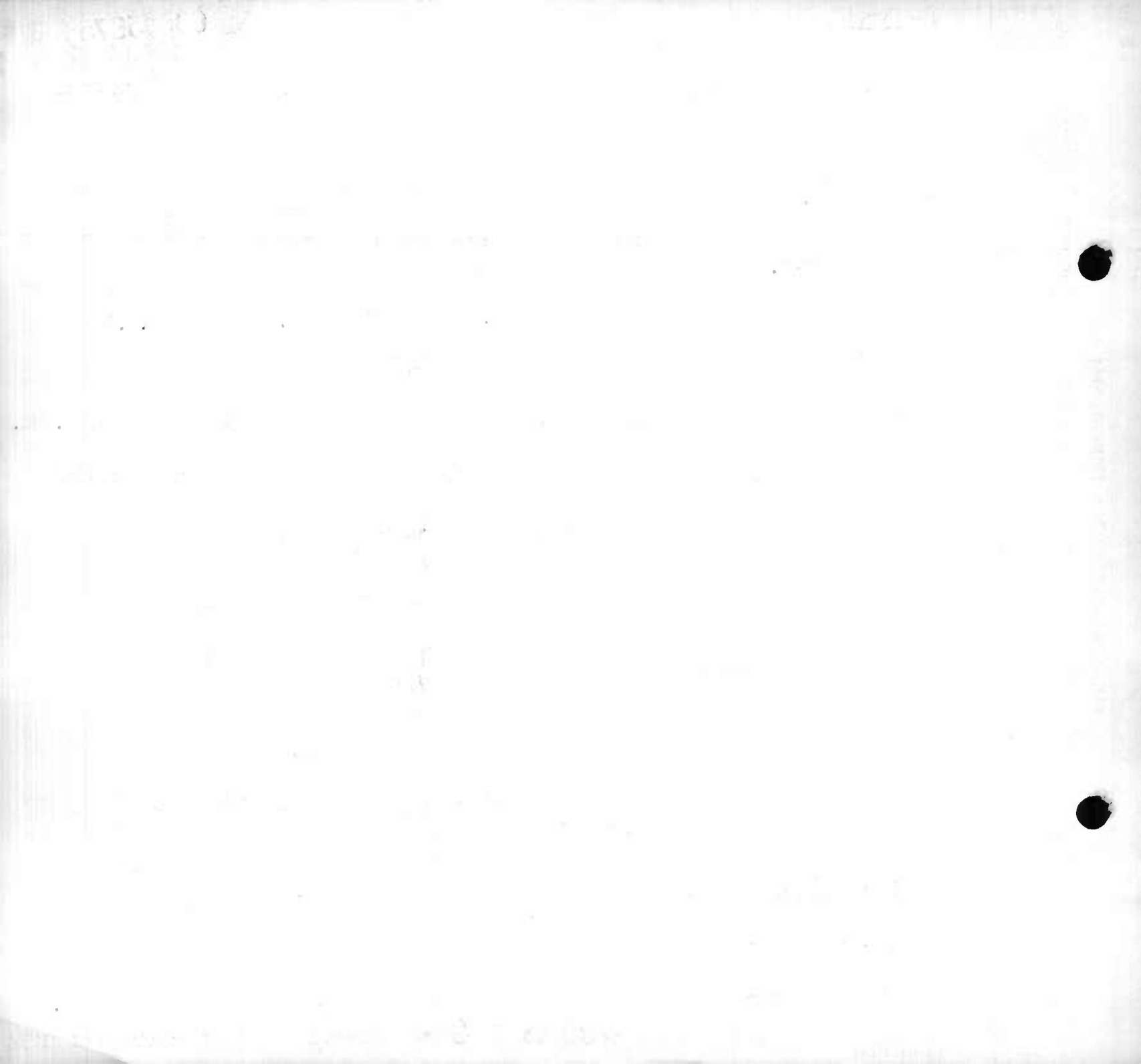
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B



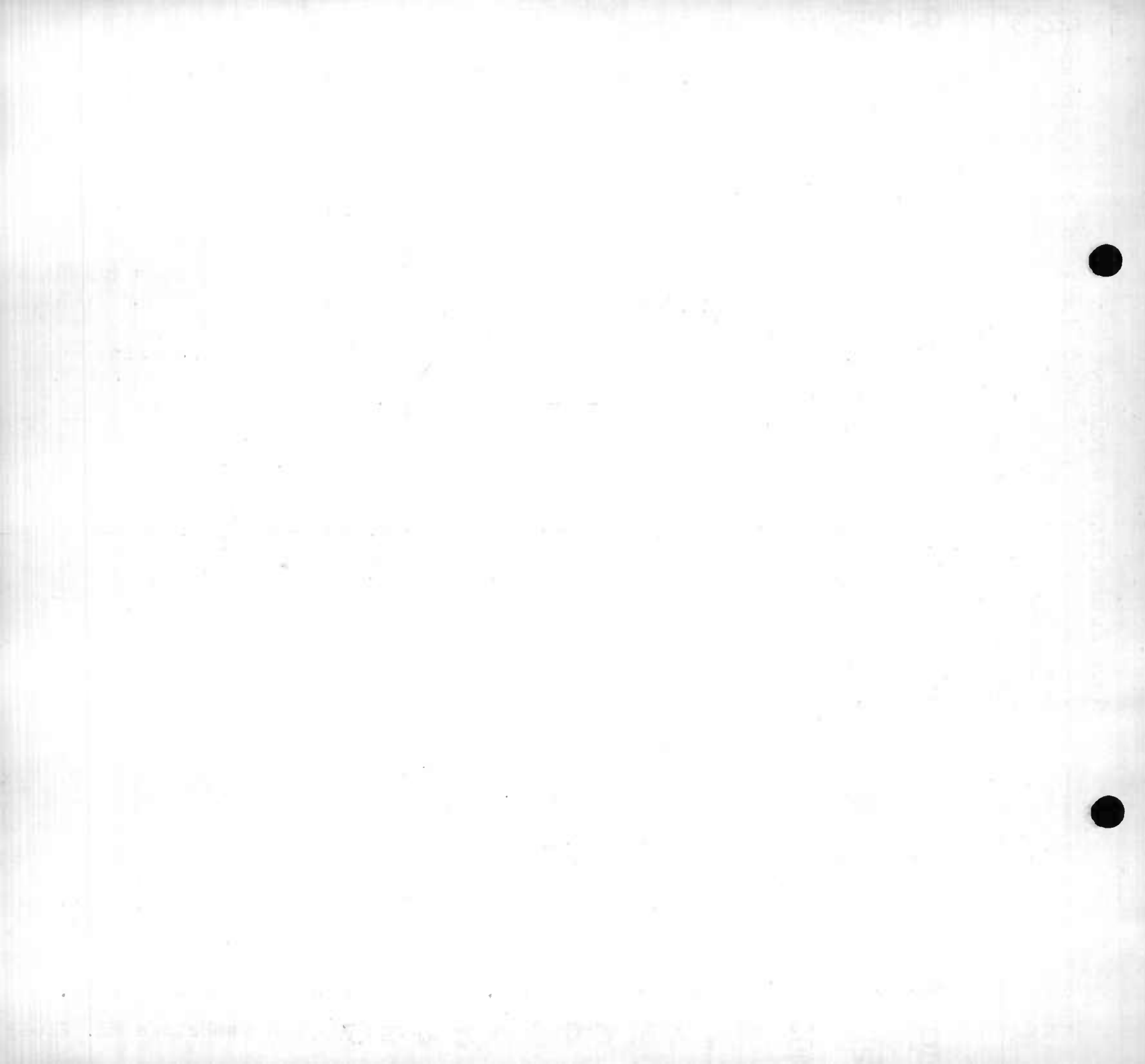
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|---|---|---|--|--|--|--|
| 69 5676 CERTIFICATE OF DEATH | | | | | REG. NO. 69 5676 | | | | |
| BIRTH NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) William TWILLEY | | | | | 2. DATE AND HOUR OF DEATH
31 MAY 1969 4:15 A M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Maryland General Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY Dorchester
C. CITY OR TOWN CAMBRIDGE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 116 BROHAWN Ave. | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
04/22/12 | 9. AGE (In years last birthday)
57 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MECHANIC | | | 10B. KIND OF BUSINESS OR INDUSTRY
Md. Tuna | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
HOUSTON TWILLEY | | | | | 14. MOTHER'S MAIDEN NAME
Florence Goslin | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
214-07-9117 | | 17. INFORMANT
WIFE | | ADDRESS
same | | |
| 18. 412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

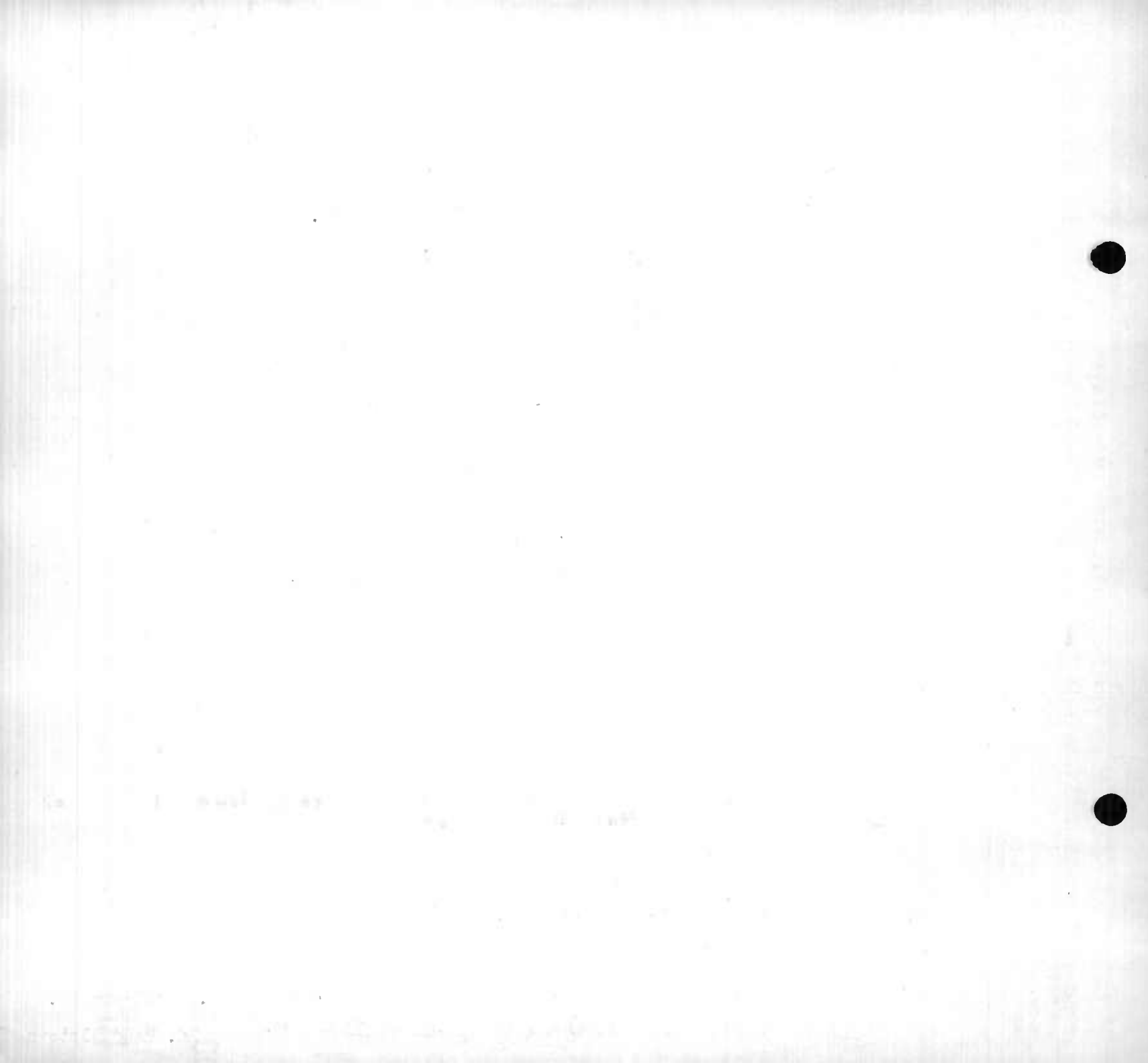
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY Embolism
(B) FEMORAL ARTERY Embolism DUE TO, OR AS A CONSEQUENCE OF:
(C) ASCVD and Chronic Heart Failure | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 05/26/69 19 to 05/31/69 19, that (2) (we) last saw the deceased alive on 05/31/69 19 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Dale P. Baker M.D. | | | | | 23B. DATE SIGNED
31 May 69 | | | 23C. PHYSICIAN'S NAME (Type)
DALE P. BAKER M.D. | |
| 23D. ADDRESS
MARYLAND GENERAL Hospital | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/3/1969 | | 24C. NAME OF CEMETERY or CREMATORY
Dorchester Mem. Park | | | 24D. LOCATION (City, town, or county) (State)
Cambridge Dorchester Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | 25B. NAME OF REGISTRAR
E. E. Baker, M.D. | | | 25C. FUNERAL DIRECTOR ADDRESS
Cambridge Md. 21613 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5677 | |
|--|---------------------|---|--|---|--|
| BIRTH NO. 69 5677 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Schwiekart, Minna A. | | 2. DATE AND HOUR OF DEATH
6-1-69 1:35 a.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
700 W 40th St | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
91 Keswick, Home For Invalids | | C. CITY OR TOWN
Owings Mills | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | STREET AND NUMBER
110 Oakmere Rd. | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1-19-1885 | 9. AGE (In years last birthday)
84 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sales lady | | 10B. KIND OF BUSINESS OR INDUSTRY
Tuerke's Gift shop | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Chas. Frederick Hahn | | 14. MOTHER'S MAIDEN NAME
Freida, Bode | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-16-8754 | | 17. INFORMANT
Vergie Crouch R.N. | |
| 18. 412.31
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Pneumonia | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
ASHD - Comp. ht. failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Hypoch dyspnoea | | (B) DUE TO, OR AS A CONSEQUENCE OF:
ASHD - Comp. ht. failure | | (C) Yes | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JUNE 13 1966 to JUNE 1 1969 , that (I) (we) last saw the deceased alive on MAY 31 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
E. Hunter Wilson, Jr., M.D. | | | | 23B. DATE SIGNED
6-2-69 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| E. Hunter Wilson, Jr., M.D. | | 700 W. 40th Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 6/4/69 | | Lorraine Park | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 3 1969 | | E. J. Bode, M.D. | | Loring Byers | |
| | | | | 8728 Liberty Rd. Randallstown | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------|---|-----------------------------------|---|--|
| 69 5678 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. 69 5678 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) BORKOWICZ, MRS. ELEANOR | | 2. DATE AND HOUR OF DEATH
6-2-69 127 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY BALTIMORE | | 5. CITY OR TOWN BOWLEYS QUARTERS D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
37 MERCY HOSPITAL BALTIMORE, MD. 21202 | | E. STREET AND NUMBER
410 BURKE RD. 21220 | | | |
| 5. SEX
FEMALE | 6. RACE
CAU | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-3-05 | 9. AGE (in years, last birthday)
63 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
BALTO. MD | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
IGNATIUS KOTECKI | | 14. MOTHER'S MAIDEN NAME
ANNA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
JOHN S. BORKOWICZ ADDRESS BOX #410 BURKE RD. BOWLEYS QUARTERS, MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
410.91
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
Extensive M.I.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) AS M.D.
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
6-5-69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
1 Month () 1 Day () 1 Year () 1 Hour () | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/1/69 19 to 6/2/69 19 that (I) (we) last saw the deceased alive on 6/2/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
AM Ghiladi | | 23B. DATE SIGNED
6/2/69 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Abdolhamid Ghiladi | | 23D. ADDRESS
Mercy Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-5-69 | | 24C. NAME OF CEMETERY or CREMATORY
SACRED HEART CEM. | |
| 24D. LOCATION (City, town, or county) (State)
7401 GERMAN HILL RD., MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Jaber, M.D. | | 25C. FUNERAL DIRECTOR
Charles S. Jailer ADDRESS 901 S. CONKLING ST. BALTO., MD. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5679

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LLOYD

MC DANIELS

2. DATE
OF
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

May 26, 1969

8:05 P

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

17-03

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

male

7. RACE

negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

11/1/13

10. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

703 W. Lafayette Avenue

11. BIRTHPLACE (State or foreign country)

Columbia, N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Mc DANIELS

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

705-12-4775

18. INFORMANT

Katie Mc DANIELS 2205 Druid Hill Balt., Md.

ADDRESS

19.

151.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Carcinoma of Stomach

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/27/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

May 31, 69

24C. NAME of CEMETERY or CREMATORY

McCalvery Cemetery Baltimore

24D. LOCATION

(City, town, or county)

(State)

Md

25A. DATE REC'D BY HEALTH DEPT

JUN 3 1969

25B. NAME OF REGISTRAR

W. E. Taylor, M.D.

25C. FUNERAL DIRECTOR

J. B. Johnson 1900 Entaw Pl Balt.

ADDRESS

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1000

1000

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R-300

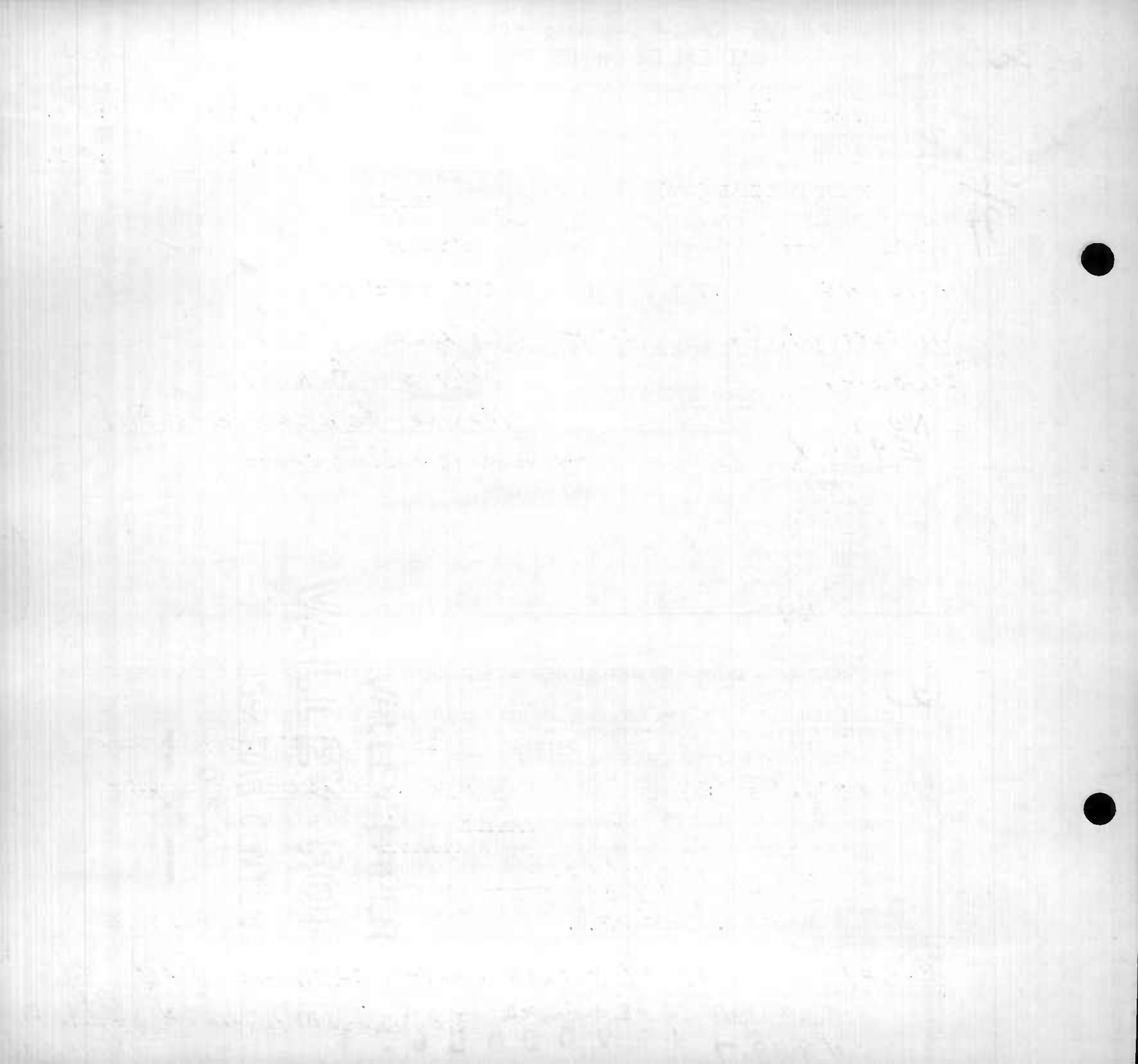
69 5680 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5680
REG. NO.

BIRTH NO.

| | | | |
|--|-------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print) JAMES REID | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> May 23, 1969
Hour 2:00 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
MERCY HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
May 23, 1969
Hour 2:00 A.M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | | |
| 6. SEX
Male | 7. RACE
Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN
Baltimore
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH
10-12-42
10. AGE (In years lost birthday) 27
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | E. STREET AND NUMBER
1711 Harford Avenue
9-09 | |
| 11. BIRTHPLACE (State or foreign country)
Wintover, N.C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Beautician | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 17. SOCIAL SECURITY NO. | |
| 13. FATHER'S NAME
Octavius Reid | | 15. MOTHER'S MAIDEN NAME
Debris Roadtree | |
| 18. INFORMANT
Maxine Reid | | ADDRESS
2220 Garrison Blvd | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
E966X | | CAUSE OF DEATH
Stab wounds of chest and abdomen
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | |
| 22D. TIME (Month) (Day) (Year) (Hour) (APPROX.)
May 23, 1969 1:40A.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
In front of 621 E. Fayette Street | | 22F. HOW DID INJURY OCCUR?
Subj. stabbed during altercation | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Ronald N. Kornblum M.D.
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 5/23/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/26/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
MT. AUBURN CEMETARY | | 24D. LOCATION (City, town, or county) (State)
Baltimore Balt. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | |
| 25C. FUNERAL DIRECTOR
J. B. Johnson | | ADDRESS
Funeral Home Estab. 1900 Balt. Md. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
KENNETH L. RUDY | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
5 31 1969 1:45 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
St. Agnes Hospital D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 31 1969 1:45 p.m. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Elkridge 21227 | |
| 9. DATE OF BIRTH
May 27, 1909 | | 10. AGE (In years lost birthday)
60 | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Secretary | | 14B. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 15. MOTHER'S MAIDEN NAME
Charlotta Wettehack | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 17. SOCIAL SECURITY NO.
705 05 4969 | | 18. INFORMANT
Minerva Rudy Same | |
| 19. CAUSE OF DEATH
412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
ANTECEDENT CAUSES
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 21. AUTOPSY? (Yes or No)
YES | |
| ACTUAL SIGNATURE
Edward F. Wilson
EXAMINER'S NAME (Type)
Edward F. Wilson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/4/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
Bruzdzinski Funeral Home | | 25D. ADDRESS
1407 Eastern Ave. | |

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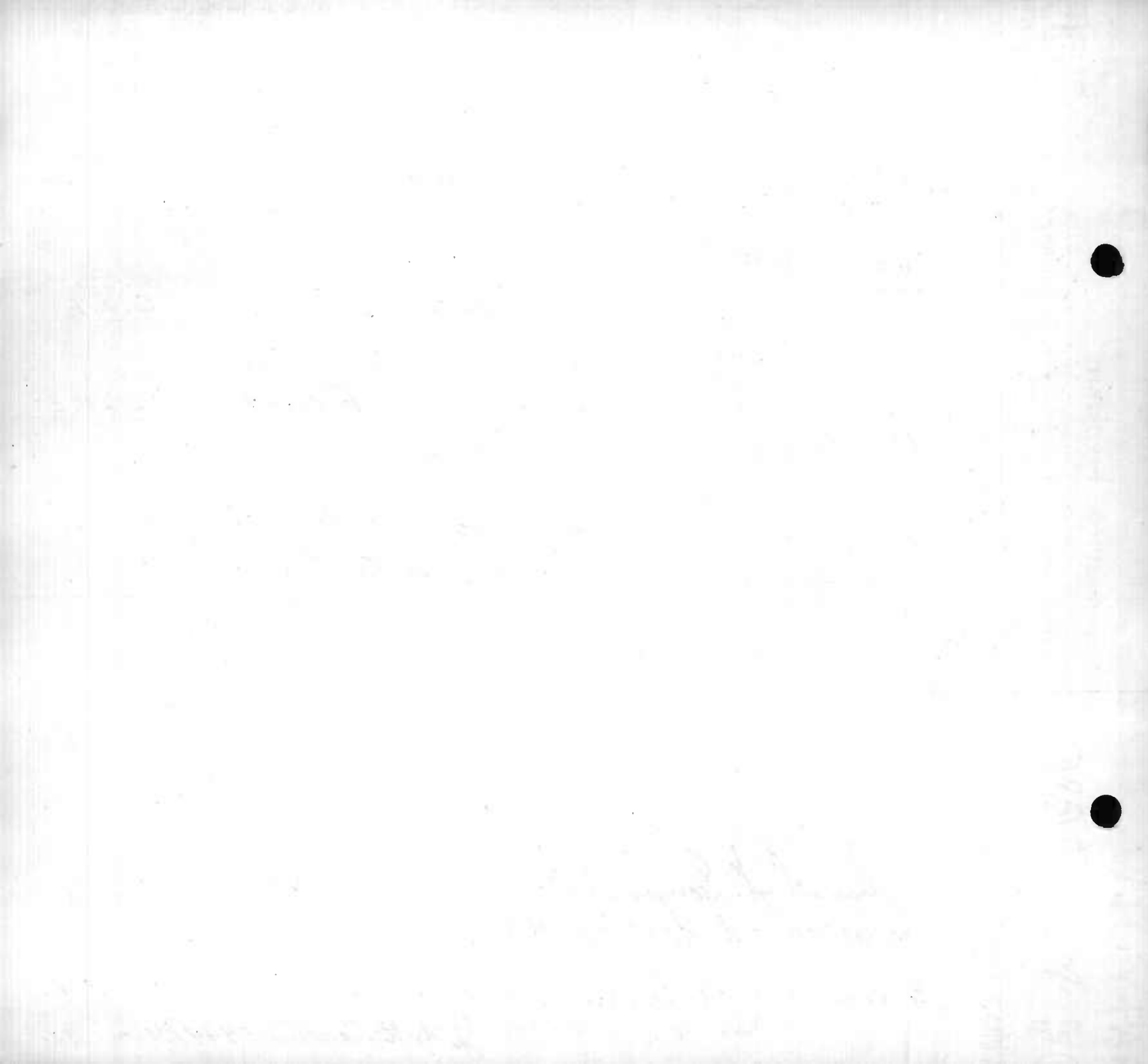
11/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5682 **CERTIFICATE OF DEATH** X REG. NO. 69 5682

| | | | | | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Richard C. ERDMAN</i> | | 2. DATE AND HOUR OF DEATH
<i>5/30/69 4:45 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>Balto. Co.</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>49 North Charles Gen Hosp
2724 N. Charles ST.</i> | | | | C. CITY OR TOWN <i>BALTO.</i> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| E. STREET AND NUMBER
<i>6038 Marquette Rd</i> | | | | | |
| 5. SEX
<i>MALE</i> | 6. RACE
<i>WHITE</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>9-19-07</i> | 9. AGE (In years last birthday)
<i>61</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Balto Police Dept</i> | | 11. BIRTHPLACE (State or foreign country)
<i>BALTO, Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 13. FATHER'S NAME
<i>Wilbur Erdman</i> | | |
| 14. MOTHER'S MAIDEN NAME
<i>Anna B. Wickes</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | |
| 16. SOCIAL SECURITY NO.
<i>213-057819</i> | | | 17. INFORMANT
<i>Chart - Family</i> | | |
| ADDRESS
<i>SAME</i> | | | | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>Bacteremia</i> | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Cancer of Ampulla of Vater</i> | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF:
<i>with metastasis</i> | | | | | |
| (C) _____ | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <i>5/2</i> 19 <i>69</i> to <i>5/30</i> 19 <i>69</i> , that (I) was last saw the deceased alive on <i>5/30</i> 19 <i>69</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Manuel A. Gongon M.D.</i> | | | | 23B. DATE SIGNED
<i>5/30/69</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>MANUEL A. GONGON M.D.</i> | | | | 23D. ADDRESS
<i>2724 N. Charles ST</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>6-3-69</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Parkwood Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>BALTO. Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 3 1969</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>J. Walter Conklin</i> | |
| ADDRESS
<i>5444 BELAIR Rd</i> | | | | | |



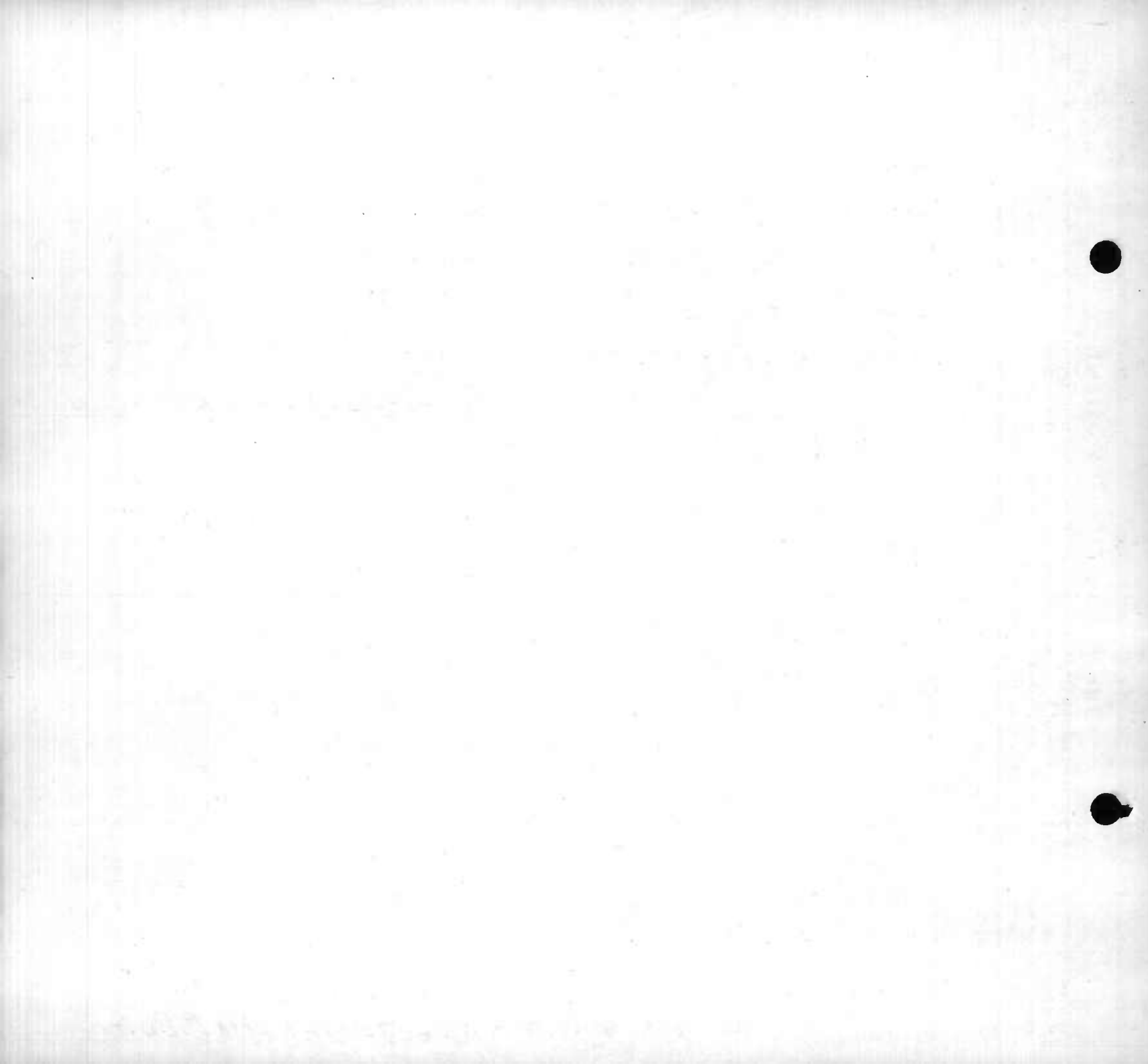
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5683 CERTIFICATE OF DEATH

REG. NO. 69 5683

| | | | | | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) ONORINA NORA LAGNA | | 2. DATE AND HOUR OF DEATH
MAY 31, 1969 10.30 P. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY 6-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
164 N. POTOMAC ST. | | C. CITY OR TOWN
BALTIMORE | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
164 N. POTOMAC ST. | |
| 5. SEX
F | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MAR. 26, 1884 | 9. AGE (In years last birthday)
85 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Italy | |
| 13. FATHER'S NAME
Stephen Prevosto | | 14. MOTHER'S MAIDEN NAME
- - - - - | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
FRANZ LAGNA | |
| | | | | ADDRESS
164 N. POTOMAC ST. | |
| 18. I
4/10/69
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Coronary Artery Disease (acute) | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Cardiac Failure
DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerotic Cardiovascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
Unknown | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C)..... | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/19 19 69 to May 31 19 69 , that (I) (was) last saw the deceased alive on May 31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Philibert Artigiani | | | | 23B. DATE SIGNED
6/2/69 | |
| 23C. PHYSICIAN'S NAME (Type)
Philibert Artigiani | | | | 23D. ADDRESS
2305 Mayfield Ave. Baltimore Md. - 21213 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-4-69 | | 24C. NAME OF CEMETERY or CREMATORY
HOLY Redeemer | |
| | | | | 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
J. E. Talbot, M.D. | | 25C. FUNERAL DIRECTOR
B. DeBortoli | |
| | | | | ADDRESS
2818 E. Baltimore St. | |

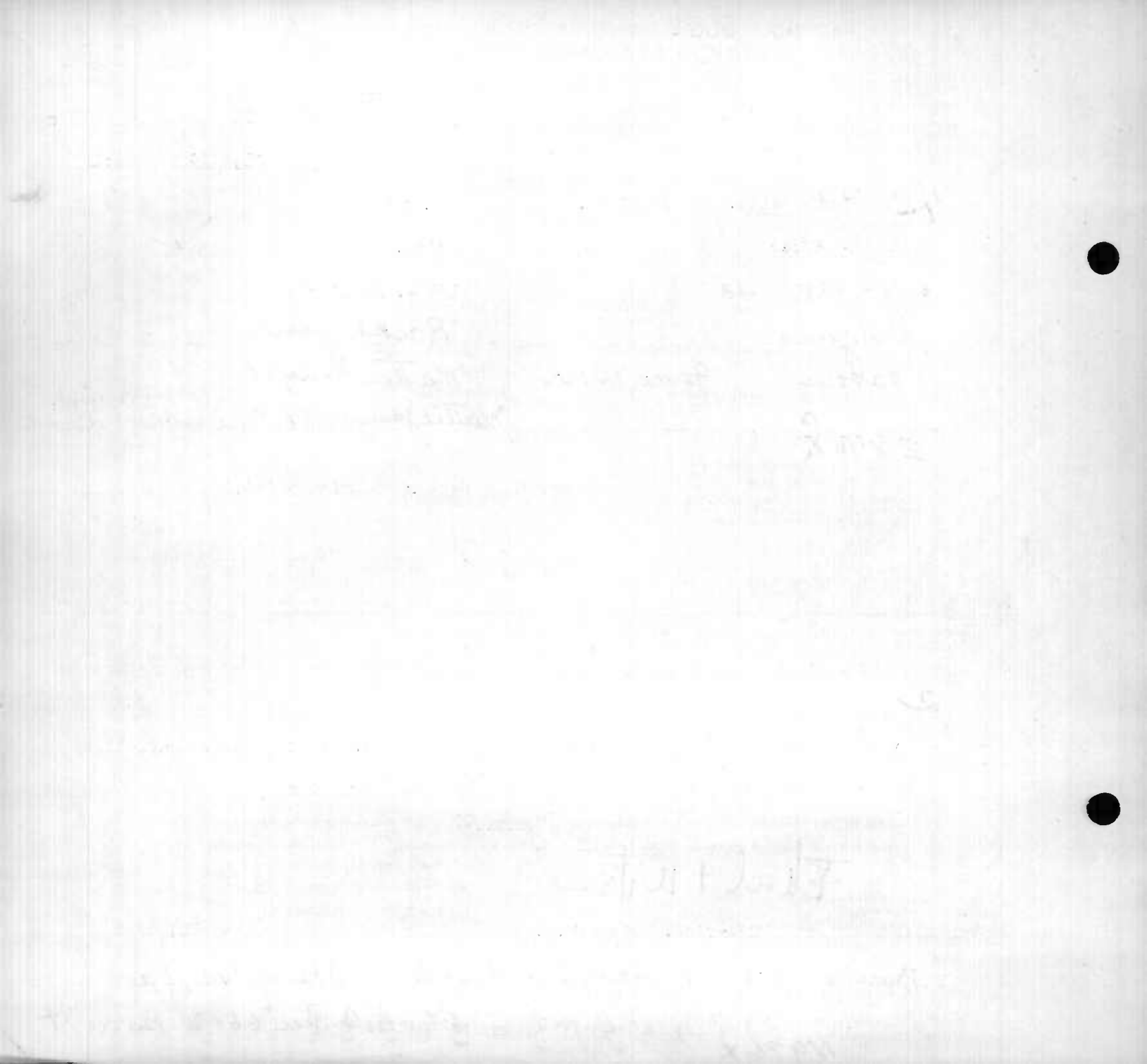


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5684

BIRTH NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
FRANK JAMES | | | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
5 31 69 4:15 a.m. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
43 South Balto. General Hosp. | | | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 31, 1969 4:15 a.m. | | | |
| 6. SEX
Male | | | | 7. RACE
Colored | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
6-10-1925 | | | | 10. AGE (In years last birthday) 43 | | | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 14B. KIND OF BUSINESS OR INDUSTRY
Fence Work | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Mattie James | |
| 19. E 890 X | | | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE Carbon monoxide poisoning
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (C) | | | |
| 20A. DATE OF OPERATION | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | | |
| 22D. TIME OF INJURY (APPROX.)
Month Day Year Hour
5 31 69 3:10 a | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
3rd fl. front 161 W. Henrietta | | | | 22F. HOW DID INJURY OCCUR?
Conflagration | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Edward F. Wilson | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
Edward F. Wilson, M.D. | | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
6-6-69 | | | |
| 24C. NAME OF CEMETERY or CREMATORY
Hampton National Cem. | | | | 24D. LOCATION (City, town, or county) (State)
Hampton, Va. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | | 25B. NAME OF REGISTRAR
Charles G. Rice | | | |
| 25C. FUNERAL DIRECTOR
Charles G. Rice | | | | ADDRESS
661 W. Barre St | | | |



5-530

69 5685

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5685

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
ARTHUR SMITH | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year Hour
Estimated <input checked="" type="checkbox"/> June 2, 1969 9:25 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 903 Ridgely Street | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 2, 1969 9:25 P.M. | |
| 6. SEX
male | | 7. RACE
negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
12-19-1915 | | 10. AGE (In years last birthday)
53 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME
Vietta Chambers | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give name or dates of service)
Yes | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
James Allen | |
| 19. 571.9 I | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Cirrhosis of the Liver with Complicating Bronchopneumonia | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
XXXXXXXXXXXXXXXXXXXX | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED
6/3/69 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-6-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Baltimore National | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
Charles A. Rice | | ADDRESS
661 W. Barre St. | |

ORDER OF THE
COURT OF COMMONS
IN THE MATTER OF
THE ESTATE OF

— 213 —

B-652

69 5686

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5686

| | | | |
|---|--|--|--|
| BIRTH NO. <i>Montgomery Co. Md</i> | | REG. NO. <i>X</i> | |
| 1. NAME OF DECEASED
(Type or Print)
LESLIE BARNES | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year Hour
Estimated <input checked="" type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Johns Hopkins Hospital | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 26, 1969 7:35 P.M. | |
| 6. SEX
female | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Prince George | |
| 7. RACE
white | | C. CITY OR TOWN
Baltimore | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | D. INSIDE CITY LIMITS?
XXXXXX NO <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH
Nov. 22, 1966 | | E. STREET AND NUMBER
12201 Rockledge Drive | |
| 10. AGE (In years lost birthday)
3 2 6 | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF
USA | | 13. FATHER'S NAME
Michael F. Barnes | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Baby | | 14B. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 15. MOTHER'S MAIDEN NAME
Beverley I. Fry | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 17. SOCIAL SECURITY NO.
None | | 18. INFORMANT
Prince George's Co., Social Services | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Fatal Concussion | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION
3 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
Yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
bathroom | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
12201 Rockledge Drive (Bowie, Md.) | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour)
5/26/69 UNK | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Subj. fell out of bathtub striking head against commode | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED
5/27/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/31/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
MIDDLETOWN CEMETERY | | 24D. LOCATION (City, town, or county) (State)
MIDDLETOWN MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
John J. Burns Sons | | ADDRESS
Towson | |

Nov. 22, 1966

Handwritten

121

Michael F. Jones

James L. Fry

At home

Body

James L. Fry, Jr. (son of James L. Fry)

Home

Home

to

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 5687 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5687 | |
|---|--------------------------|---|--|--|--|---|---|
| 1. NAME OF DECEASED
(Type or Print) JENNIE WALDORF | | | | 2. DATE AND HOUR OF DEATH
6-2-69 11:25 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE md B. COUNTY 27-17 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
LEVINDALE HEBREW HOME AND INFIRMARY, BALTO, MD | | | | C. CITY OR TOWN
Balto | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
Belvedere & Green Spring Ave | | | |
| 5. SEX
F | 6. RACE
JEWISH | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9/12/1875 | 9. AGE (In years last birthday)
93 | 10. Under 1 yr. Months: 0 Days: 0 | 11. Under 24 Hrs. Hours: 0 Min: 0 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Moses | | | | 14. MOTHER'S MAIDEN NAME
T. Leusa | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
_____ | | 17. INFORMANT
Levindale | | ADDRESS
Same | |
| 18. 788.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Dehydration, Uremia | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Dehydration, Uremia | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Dysphasia Cause unknown | | | | (B) DYSPHASIA CAUSE UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF:
_____ | | | |
| (C) _____ | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
_____ | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-2-1963 to 6-2-1969 , that (I) (we) last saw the deceased alive on 6-2-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Jane Younghea Lew | | | | DEGREE
Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
6-2-69 | |
| 23C. PHYSICIAN'S NAME (Type)
JANE Younghea LEW | | 23D. ADDRESS
_____ | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/4/69 | | 24C. NAME OF CEMETERY or CREMATORY
Hebrew Friendship Balto | | 24D. LOCATION (City, town, or county) (State)
md | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
James E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Stephen S. Lewis & Son | | ADDRESS
960 Reisterstown Rd | |

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at the end of the line

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5688

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print)
GERALD GIORDANO | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month 6 Day 1 Year 69 Hour 1:00 p.m.
Estimated <input type="checkbox"/> | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
31 City Hospital | | 3. DATE PRONOUNCED DEAD
Month June Day 1 Year 1969 Hour 1:00 p.m. | |
| 6. SEX Male 7. RACE White | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY BALTO | |
| 8. MARIED <input type="checkbox"/> NEVER MARIED <input checked="" type="checkbox"/> C. CITY OR TOWN Balto.
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 9. DATE OF BIRTH 8/19/97 10. AGE (In years lost birthday) 71 | | E. STREET AND NUMBER 129 Riverside Rd. | |
| 11. BIRTHPLACE (State or foreign country) ITALY | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 13. FATHER'S NAME PASQUALE GIORDANO | |
| 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME ANTONIA? G1220 | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 17. SOCIAL SECURITY NO. 195-09-4633 | |
| 18. INFORMANT KITTY GUTENBERGER | | ADDRESS ABOVE | |
| 19. CAUSE OF DEATH
E 814.7
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

II
20A. DATE OF OPERATION
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
21. AUTOPSY? (Yes or No)
No | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE Multiple injuries with complicating pneumonia
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Mace Ave. 10' S. of Franklin Ave. | | 22D. TIME OF INJURY (APPROX.)
Month 4 Day 12 Year 69 Hour 7:32 pm | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Pedestrian | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE Edward F. Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED June 2, 1969 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
REMOVAL | | 24B. DATE
6/2/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
MT. CALVARY | | 24D. LOCATION (City, town, or county) (State)
GREENBURG N.Y. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Edward E. Tabor, M.D. | |
| 25C. FUNERAL DIRECTOR
CONNELLT SONS | | ADDRESS
300 MACE | |

W-11

INTERVIEW WITH GREENBERG
RE: GREENBERG, ALICE
GREENBERG, ALICE
GREENBERG, ALICE

2/11/71
1971

DATE

2/11/71

REPORT
WILLIAM W. CARR
GREENBERG, ALICE
300 400

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

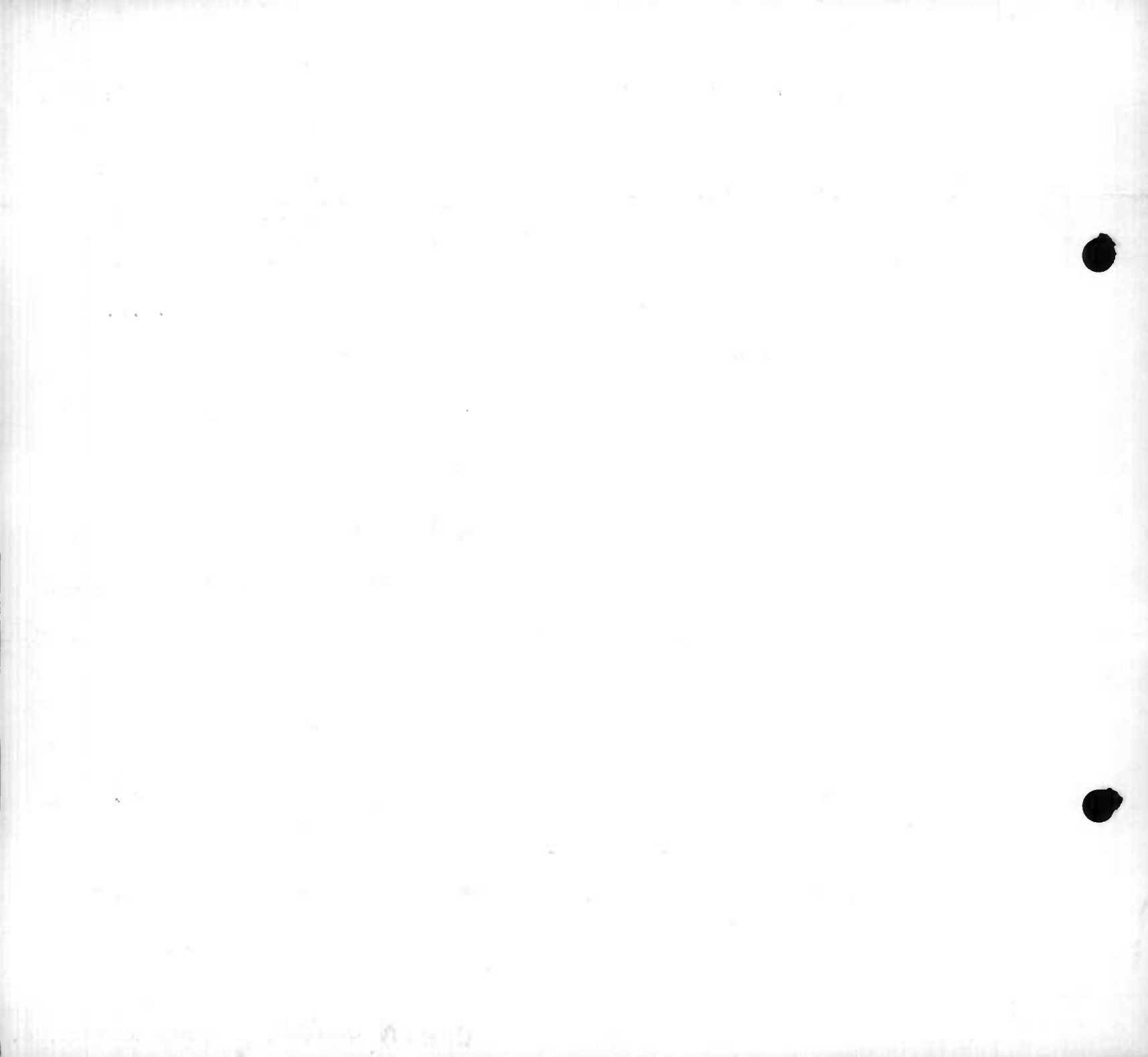
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5689 | |
|---|--|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> H-600 69 5689 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) John M. Heuer | | | 2. DATE AND HOUR OF DEATH
June 2, 1969 5:15 a.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hosp. | | | 4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission)
A. STATE md.
B. COUNTY 9-06 | | |
| 5. SEX MALE | | | 6. RACE WHITE | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 12/7/88 | | |
| 9. AGE (In years last birthday) 80 | | | 10. AGE (In years last birthday) 80 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | 10B. KIND OF BUSINESS OR INDUSTRY
JANITOR | | |
| 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD. | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 13. FATHER'S NAME
August Heuer | | | 14. MOTHER'S MAIDEN NAME
Mary Healy | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
216-10-9782 | | |
| 17. INFORMANT
ELIZABETH D. SCHICK | | | ADDRESS 1900 EASTFIELD RD BALTO. 21222, MD | | |
| 18. CAUSE OF DEATH
427.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Beach pneumonia.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Caused Heart Failure.
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
II | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 31 19 69 to June 2 19 69 , that (I) (we) last saw the deceased alive on June 2 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Charles R. Goshen | | | | 23B. DATE SIGNED
June 2, 1969 | |
| 23C. PHYSICIAN'S NAME (Type)
CHARLES R. GOSHEN, M.D. | | | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-5-69 | | 24C. NAME OF CEMETERY or CREMATORY
MEADOWRIDGE MEMORIAL | |
| 24D. LOCATION (City, town, or county) (State)
WASH. BLVD & DORSEY RD. ELK RIDGE, MD. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | | |
| 25B. NAME OF REGISTRAR
John E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Charles S. Juler | | | |
| ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD. | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5690 | |
|--|---------|---|---|--|--|
| BIRTH NO. Wicomico Co. Md. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| WARD, Paul Robert | | | 5/29/69 3:00 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| The Johns Hopkins Hospital | | | Maryland Worcester 72-00 | | |
| C. CITY OR TOWN | | | D. INSIDE CITY LIMITS? | | |
| Stockton, Md. | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| E. STREET AND NUMBER | | | RFD Stockton, Md. 21864 | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | 10. UNDER 1 Yr. Months Days |
| Male | White | | 1/4/69 | -- | 4 25 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| --- | | --- | | Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Mack Robert Ward | | | Mary Hall | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no -- | | none | | M. Robert Ward, Stockton, Maryland | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | 3 hrs. |
| | | | (B) PULMONARY HYPOPERFUSION
DUE TO, OR AS A CONSEQUENCE OF: | | 3-4 hrs. |
| | | | (C) CONGENITAL CHANOTIC CARDIAC DISEASE
DUE TO, OR AS A CONSEQUENCE OF: | | since birth |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | ? TRANSPOSITION of the Great Vessels | | since birth |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 5/28/69 | | TRANSPOSITION of Great Vessels - Disease | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| No | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (if this hospital) attended the deceased from 5/28 19 69 to 5/29 19 69 that (if we) last saw the deceased alive on 5/29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| DENIS H. TYRANS, M.D. | | | | 5/29/69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| DENIS H. TYRANS, M.D. | | | | JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY | |
| Burial | | 6-1-1969 | | Gunby Presbyterian | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 3 1969 | | E. Gaber, M.D. | | Robert H. Watson | |
| 24D. LOCATION (City, town, or county) (State) | | | | ADDRESS | |
| Stockton, Maryland | | | | Pocomoke City, Md. | |

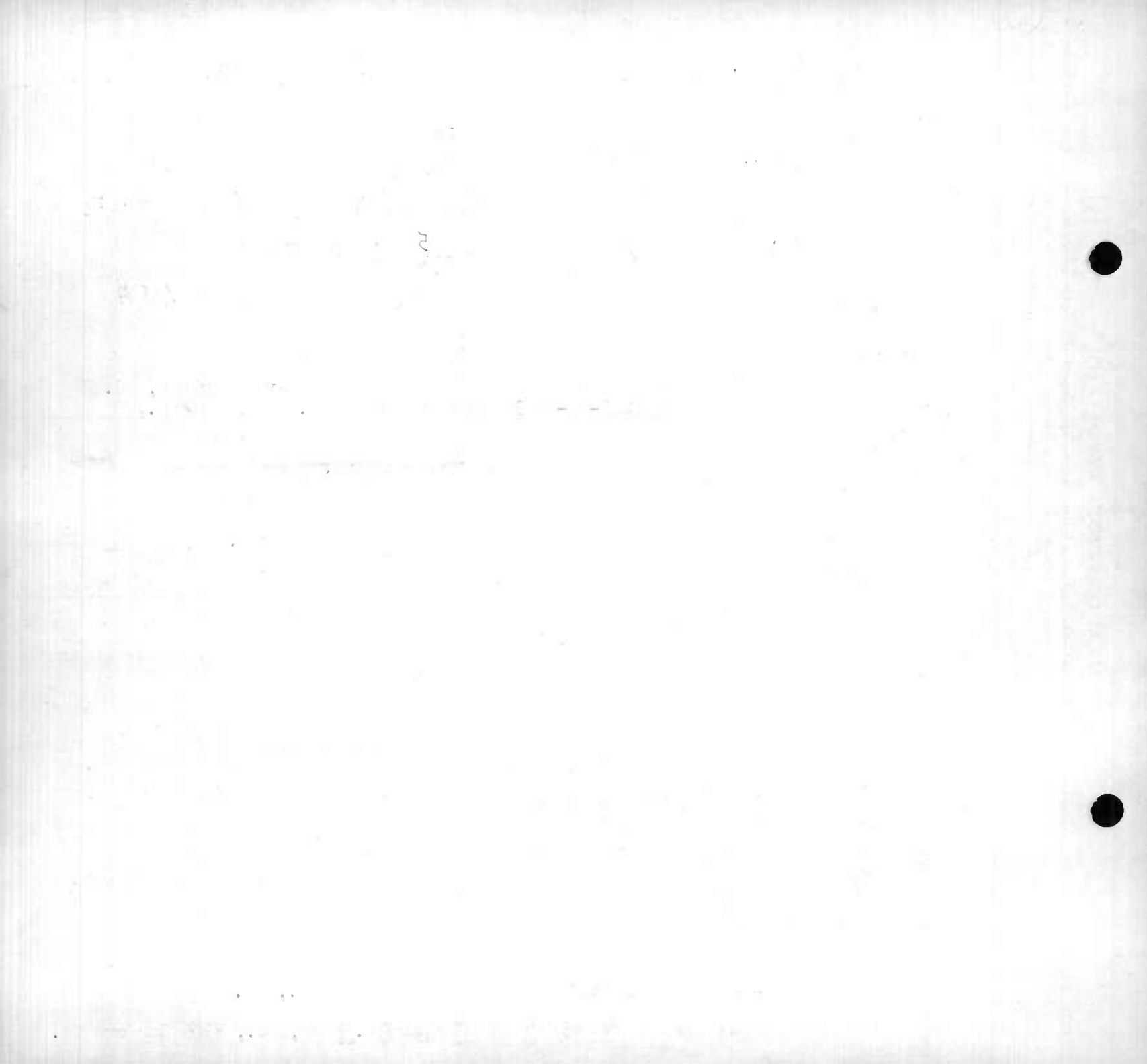


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5691 |
|---|-------------------------|--|---|--|
| BIRTH NO.
1. NAME OF DECEASED
(Type or Print) LILLIAN E. BRASS | | 69 5691 CERTIFICATE OF DEATH
2. DATE AND HOUR OF DEATH
June 2, 1969 12 Noon | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSP.
1332 CALVERT STS.
BALTO 18, MD. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY 26-41
5. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 5407 GERLAND AVE, BALTO 6. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/21/1895 | 9. AGE (In years last birthday) 73
If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
MD. | | |
| 11. BIRTHPLACE (State or foreign country)
MD. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
August Twele | | 14. MOTHER'S MAIDEN NAME
Katherine Herrmann | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-05-6663D | | 17. INFORMANT Silver Springs, Md.
Mary Knapman, 6 E. Hamilton Ave. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
492 X I
multiple pulmonary embolism
myocardial infarction
Pulmonary emphysema | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF:
D.H. | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
6/2/69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 6/2/69 to 6/2/69, that (I) (we) last saw the deceased alive on 6/2/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Charles E. Beck
23C. PHYSICIAN'S NAME (Type) R. Beck | | | 23B. DATE SIGNED
6/2/69
23D. ADDRESS
23. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-5-69 | | 24C. NAME OF CEMETERY or CREMATORY
Moreland |
| 24D. LOCATION (City, town, or county) (State)
Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | |
| 25B. NAME OF REGISTRAR
Walter S. Beck, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Beck, Inc., 5305 Harford Rd. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

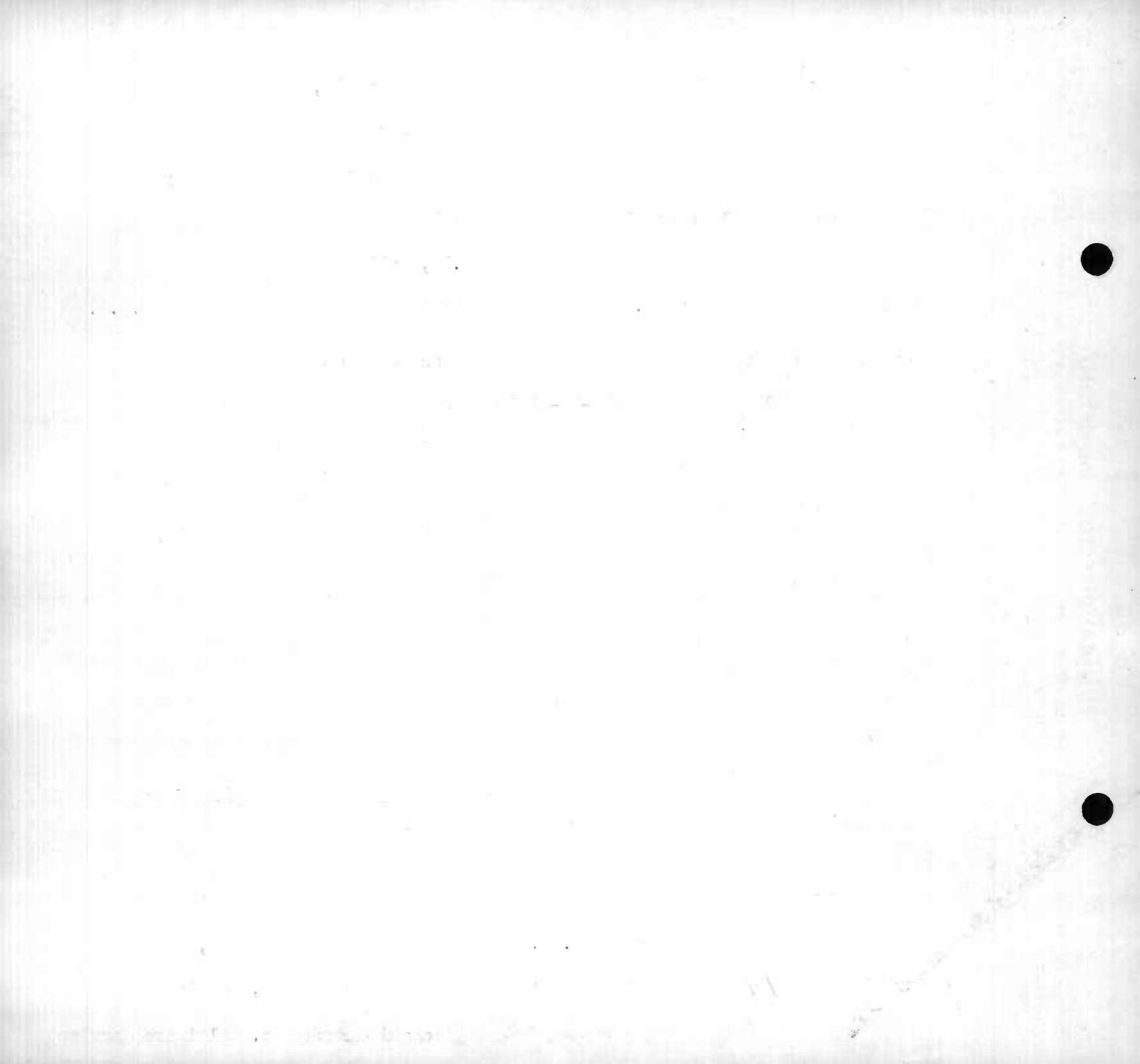
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 69 5692

| | | | | | | | |
|---|-------------------------|---|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Walter G Dell | | 2. DATE AND HOUR OF DEATH
May 30, 1969 | | M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
44 Union Memorial Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 9-06
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1924 E. 29th St | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 15, 1922 | 9. AGE (In years last birthday) 46 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Policeman | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. City | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Walter G Dell Sr | | | | 14. MOTHER'S MAIDEN NAME
Grace J Abbott | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW 11 | | 16. SOCIAL SECURITY NO.
217-16-2281 | | 17. INFORMANT
Mrs Geneva P Dell | | ADDRESS
Same | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
4/10/69 Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF:
(A) IMMEDIATE CAUSE
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10 June 1965 to 30 May 1969 , that (I) (we) last saw the deceased alive on 30 May 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Anderson M Renick Jr | | | | 23B. DATE SIGNED
6/2/69 | | 23C. PHYSICIAN'S NAME (Type)
Anderson M Renick Jr M.D. | |
| 23D. ADDRESS
1101 St Paul St Baltimore, Maryland | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/3/69 | | 24C. NAME OF CEMETERY or CREMATORY
Lake View Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Robert E. Harley, M.D. | | 25C. FUNERAL DIRECTOR
Lebanon J. Buck Inc. | | ADDRESS
Baltimore Maryland | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 69 5693 |
|--|----------------------------|--|---|---|---|
| BIRTH NO.
1. NAME OF DECEASED
(Type or Print) <u>Eugene Irvin Barnes</u> | | 2. DATE AND HOUR OF DEATH
<u>5/31/69</u> <u>11</u> <u>PM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>425 Sinai</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>15-12</u>
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>2902 Norfolk Ave</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4/15/12</u> | 9. AGE (In years last birthday) <u>57</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME
<u>Milton Barnes</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Annie</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Nannie Barnes</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>Uremia</u>
DUE TO, OR AS A CONSEQUENCE OF:

(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>?</u> | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>metabolic Acidosis</u> | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/31</u> <u>19</u> <u>69</u> to <u>5/31</u> <u>19</u> <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/31</u> <u>19</u> <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Barton A. Cohen</u>
23C. PHYSICIAN'S NAME (Type)
<u>Barton Cohen</u> | | | | 23B. DATE SIGNED
<u>5/31/69</u> | |
| 23D. ADDRESS
<u>Sinai Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6-5-69</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Abbutus Mem. Park</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 9 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, R.D.</u> | | 25C. FUNERAL DIRECTOR
<u>V.R. Bailey</u> | |
| ADDRESS
<u>Kelson Funeral Home 1348 Calhoun St</u> | | | | | |

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Handwritten notes at the top right, possibly a date or reference number.

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Handwritten notes in the middle right section.

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Handwritten notes at the bottom center.

Handwritten notes at the bottom right, possibly a signature or date.

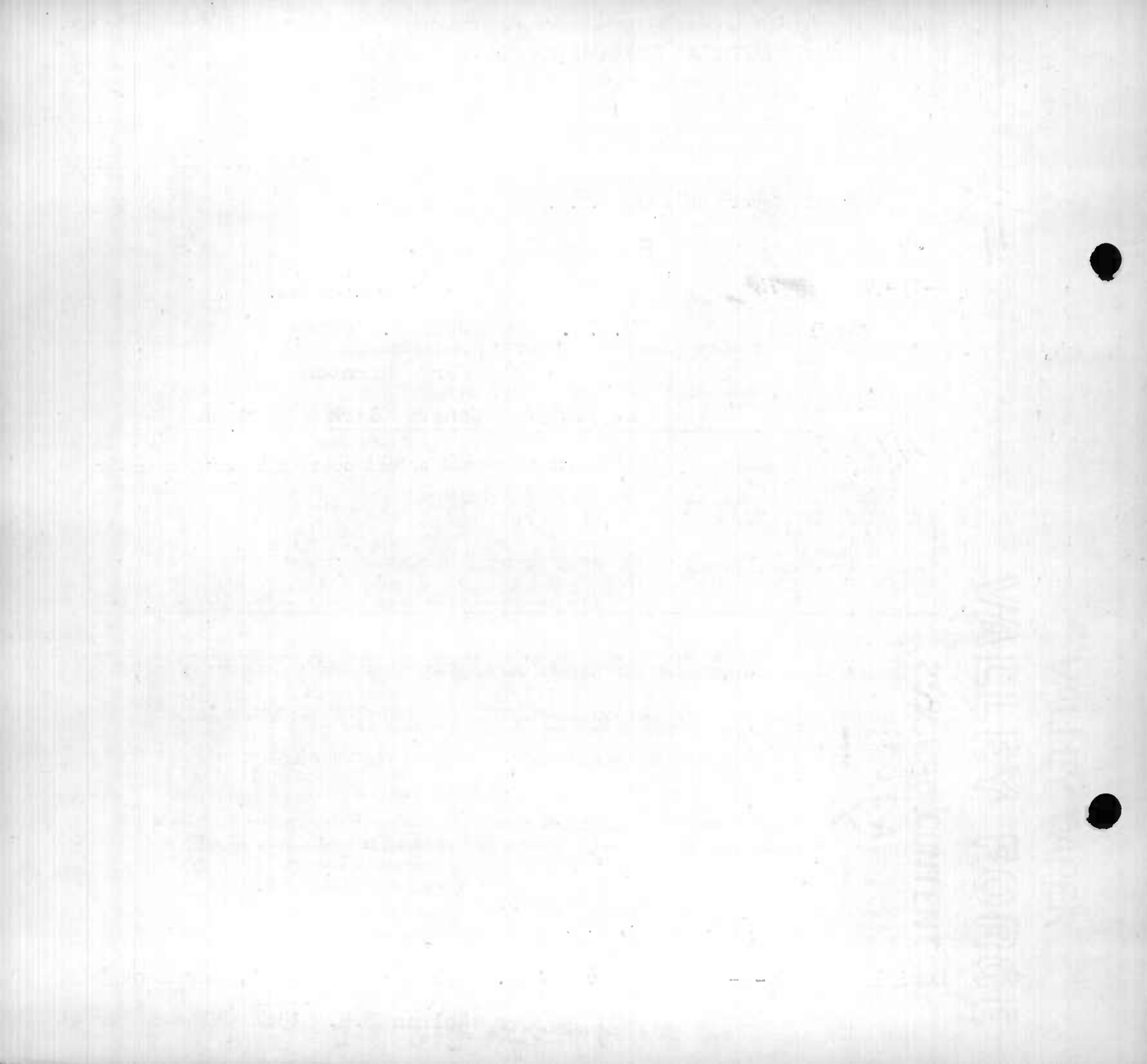
1
B-200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
RUTH BOOZE | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> 6 1 69 6:10 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Franklin Square Hospital D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 1, 1969 6:10 p.m. | |
| 6. SEX
Female | | 7. RACE
Colored | |
| 8. DATE OF BIRTH
8-13-94 | | 10. AGE (In years last birthday)
74 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 17. SOCIAL SECURITY NO.
213320556 | |
| 18. INFORMANT
Geneva Clark | | ADDRESS
same | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Hypertensive and arteriosclerotic cardiovascular disease | | CAUSE OF DEATH
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (Approx.) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 21. AUTOPSY? (Yes or No)
No | |
| ACTUAL SIGNATURE
Edward F. Wilson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-5-69 | |
| 24C. NAME of CEMETERY or CREMATORY
Carver Mem. Park | | 24D. LOCATION (City, town, or county) (State)
Laurel, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Kelson F.H. | |
| 25C. FUNERAL DIRECTOR
V. Bailey | | ADDRESS
1348 Calhoun Street | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | REG. NO. <u>69 5695</u> |
|---|-------------------------|---|---|--|---|-------------------------|
| BIRTH NO. <u>69 5695</u> | | CERTIFICATE OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Vernetta Franklin</u> | | | 2. DATE AND HOUR OF DEATH
<u>6-1-69</u> <u>12:25 p.m.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>39</u> <u>Provident Hospital, Inc.</u>
<u>1514 Division Street</u>
<u>Baltimore, Maryland 21217</u> | | | A. STATE <u>Maryland</u>
B. COUNTY <u>15-01</u> | | | |
| | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | E. STREET AND NUMBER
<u>1635 Vincent Court</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4-12-05</u> | 9. AGE (in years last birthday)
<u>64</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | |
| 13. FATHER'S NAME
<u>Edward Cager</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Maggie Nicholson</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Connor</u>
<u>Mrs. Hazel Carter-daughter</u> | | |
| | | | | ADDRESS <u>Same</u> | | |
| 18. <u>436.0 I</u> CAUSE OF DEATH | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | | |
| (A) IMMEDIATE CAUSE <u>CVA.</u>
DUE TO, OR AS A CONSEQUENCE OF: | | | | | | |
| (B) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF: | | | | | | |
| (C) _____ | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May 21,</u> 19 <u>69</u> to <u>June 1,</u> 19 <u>69</u>
that (I) (we) lost the deceased alive on <u>June 1,</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | 23B. DATE SIGNED
<u>6-2-69</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>A. Khan M.D.</u> | | | 23D. ADDRESS
<u>1514 Division Street Balto., Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6-5-69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Mt. Auburn Cem.</u> | | |
| 24D. LOCATION
<u>Balto. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, Jr.</u> | | 25C. FUNERAL DIRECTOR
<u>V.R. Bailey</u> | | | | |
| 25D. ADDRESS
<u>1348 N. Calhoun St.</u> | | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print)
ROBERT MALONE | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> May 29, 1969
Hour 11:55 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
PROVIDENT HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
May 29, 1969
Hour 11:55 P.M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 16-03 | | | |
| 6. SEX
Male | 7. RACE
Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
July 9, 1953
10. AGE (In years last birthday) 15
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | C. CITY OR TOWN
Baltimore
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | E. STREET AND NUMBER
1101 N. Mount Street | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Robt. Malone | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME
Bertha Thacker | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
no | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
Bertha Malone | | ADDRESS
1101 Mount St. | |
| 19. 304.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Bronchopneumonia
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Intravenous Narcotism
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
Yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 5/30/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-4-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
Ronald E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
Kelson F.H. | | ADDRESS
1348 N. Calhoun St. | |

Handwritten signature or scribble.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5697

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5697

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Levi Harris</u> | | 2. DATE AND HOUR OF DEATH
<u>6-1-69</u> <u>2:45</u> P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>15-01</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>39</u>
Provident Hospital, Inc.
1514 Division Street
Baltimore, Maryland 21217 | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
<u>Male</u> | | 6. RACE
<u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
<u>7-20-40</u> | | 9. AGE (in years last birthday)
<u>28</u> | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Wallace Harris</u> | | 14. MOTHER'S MAIDEN NAME
<u>Virginia Pinkird</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mary McCargo 1379 Whatcoat St.</u>
<u>Mrs. Barbara Matthews-Sister</u> <u>Same</u> | |
| 18. <u>436.9 + 1303.9</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>Alcoholism</u> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>CVA?</u>
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
<u>6</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>May 31</u> , 19 <u>69</u> to <u>June 1</u> , 19 <u>69</u>
that (I) (we) last saw the deceased alive on <u>June 1</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | M. Degree <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>6-2-69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>A. Khan, M.D.</u> | | 23D. ADDRESS
<u>1514 Division Street Balto., Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6-5-69</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Mt. Auburn Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Balto. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>V.R. Bailey</u> ADDRESS
<u>Kelson P.H. 1348 N. Calhoun St.</u> | | | |



69 5698

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5698

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CHARLES VODERY

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

May 23, 1969

10:00 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

1424 Argyle Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

May 23, 1969

10:00 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

14-02

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

APRIL 20, 1905

10. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1424 Argyle Avenue

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

CHARLES VODERY

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CHIEF

14B. KIND OF BUSINESS OR INDUSTRY

Food

15. MOTHER'S MAIDEN NAME

RUBY G. HAUGHTON

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

217-059448

18. INFORMANT

MILDRED BREVES

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Cirrhosis of Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Ronald N. Kornblum, M.D.

EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/23/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/1/69

24C. NAME OF CEMETERY or CREMATORY

MT ROBERT CEMETERY WESTPORT MD

24D. LOCATION (City, town, or county)

WESTPORT MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

KELSON FUNERAL WESTPORT

JUN 3 1969

FUNERAL DIRECTOR: IMPORTANT

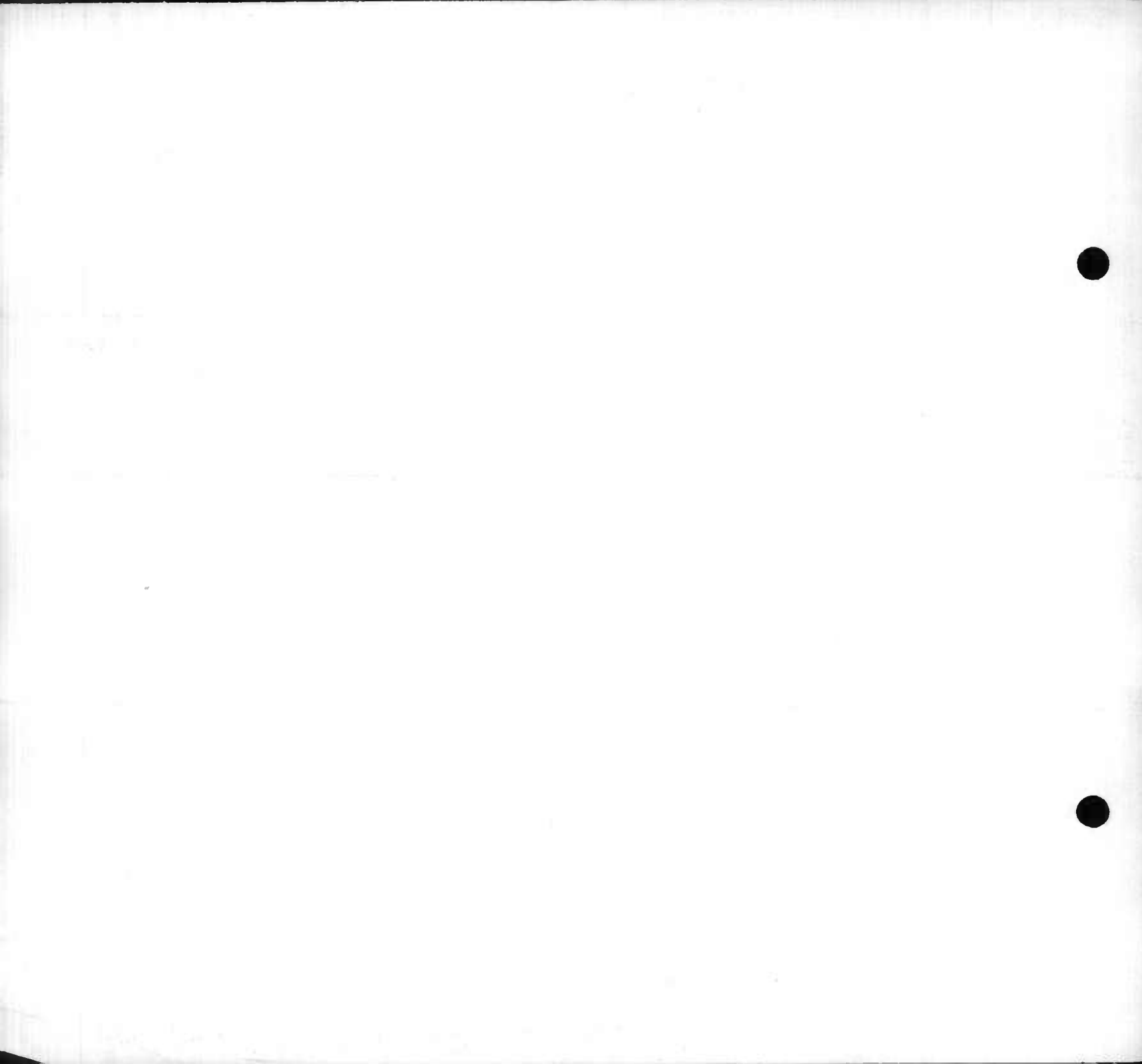
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5699 | |
|--|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>GIFFORD, THERESA MARY</u> | | 2. DATE AND HOUR OF DEATH
<u>2 JUN 69</u> <u>0610 a.m.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
<u>JOHNS HOPKINS HOSPITAL</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>7-02</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>JOHNS HOPKINS HOSPITAL</u> | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | C. CITY OR TOWN
<u>BALTIMORE</u> | |
| 5. SEX
<u>F</u> | | 6. RACE
<u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
<u>3/31/16</u> | | 9. AGE (in years last birthday)
<u>53</u> | | 10. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>HOME</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | |
| 13. FATHER'S NAME
<u>Wm. M. FABER</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary E. KEEN</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>-</u> | | 17. INFORMANT
<u>Mrs. Mary E. Faber - 505 N. Belvidere Ave.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>HEART FAILURE</u> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>HEART FAILURE</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>< 24 hrs</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>CHRONIC RENAL DISEASE</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>CHRONIC RENAL DISEASE</u> | | <u>> 5 yrs.</u> | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Fracture of Right Femur</u> | | | | <u>1 month.</u> | |
| 19A. DATE OF OPERATION
<u>12 May 69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>II</u> | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>yes</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>HOME</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>505 BELVIDERE AVE</u> | |
| 21D. TIME OF INJURY (APPROX.)
<u>MAY 1 69</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>TRANSFERRING FROM W. CHAIR TO COMMODE</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3 May</u> 19 <u>69</u> to <u>2 JUNE</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>2 JUNE</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Thomas A. Otter</u> MD. | | | | 23B. DATE SIGNED
<u>2 June 69.</u> | |
| 23C. PHYSICIAN'S NAME (Typed)
<u>THOMAS A. OTTER</u> | | | | 23D. ADDRESS
<u>JOHNS HOPKINS HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>6-5-69</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>PARKWOOD CEMETERY</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>BALTO., MD.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>11 821.0 JUN 3 1969</u> | | 25B. NAME OF REGISTRAR
<u>John E. Faber, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Garth G. Galt - 2334 Jefferson St.</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 69 5700 CERTIFICATE OF DEATH X REG. NO. 69 5700 | | | | | | | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Shaffer Roy Noah</u> | | | | 2. DATE AND HOUR OF DEATH
<u>31 May 1969</u> <u>1450</u> P M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>PA.</u> B. COUNTY <u>YORK</u> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>University of Maryland Hosp.</u> | | | | | | C. CITY OR TOWN
<u>HANOVER</u> | | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER
<u>RD 3</u> | | | | | | | | | | | |
| 5. SEX
<u>M</u> | | 6. RACE
<u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>5-12-93</u> | | 9. AGE (in years last birthday)
<u>76</u> | | 10. Under 1 Yr. Months Days If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>FARMER</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>FARMER</u> | | | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Wesley Shaffer</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>SARAH E. Keeler</u> <u>KEELER</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> <u>9-27-1917-5-26-1919</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>CHART</u> | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>CARCINOMA OF Rectum</u>
<u>c metastases</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>None</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>26 April 69</u> 19 <u>69</u> to <u>31 May 1969</u> 19 <u>69</u> and that (I) (we) last saw the deceased alive on <u>31 May 1969</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<u>Edward D. Layne</u> | | | | | | 23B. DATE SIGNED
<u>31 MAY 1969</u> | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Edward D. Layne</u> | | | | | | 23D. ADDRESS
<u>University of Maryland Hosp.</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 24B. DATE
<u>6-5-1969</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Stone Church Cemetery</u> | | | | 24D. LOCATION (City, town, or county) (State)
<u>Bradbecks York Co Pa</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | | | 25C. FUNERAL DIRECTOR
<u>Tipton & Sons - Hampstead, Md.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Oscar C. Buser</u> | | 2. DATE AND HOUR OF DEATH
<u>6/3/69</u> <u>11:45 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>48 Maryland General Hospital</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>M</u> | | 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Produce Specialist</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>G. A. + P. Tea Co</u> | | 8. DATE OF BIRTH <u>8/13/14</u> 9. AGE (In years last birthday) <u>54</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Switzerland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>Henry Buser</u> | | 14. MOTHER'S MAIDEN NAME
<u>Elise Mohler</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>yes WW2</u> | | 16. SOCIAL SECURITY NO.
<u>214-05-1334</u> | | 17. INFORMANT <u>Patient</u> ADDRESS <u>Same</u> | |
| 18. <u>162.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>CARDIAC TAMPONADE</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>MIN 3</u>
<u>3 MONTHS</u> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>CARCINOMA of LUNG</u>
<u>INVASION OF ADIPASCUM</u> | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>LONG</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>3 MONTHS</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>Pl. never seen</u> | | | | | |
| 23A. SIGNATURE
<u>B. Ann Zwald, M.D.</u> | | | | 23B. DATE SIGNED
<u>6/3/69</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 23E. DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/6/69</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Moreland Mem. Pk.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Balto. Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 3 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Bailey, R.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Leonard J. Buck Inc.</u> ADDRESS <u>Balto. Md.</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | | | | | | | | | |
|---|-------------------------|--|---|---|--|---|--|--|--|--|--|--|--|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) MARIAN SHINDLE | | 2. DATE AND HOUR OF DEATH
MAY 31 1969 11:00 P.M. | | | | | | | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 3-02 | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
35 CHURCH HOME AND HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Church Home & Hospital | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| | | E. STREET AND NUMBER
1228 E. BALTIMORE STN | | | | | | | | | | | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-9-97 | 9. AGE (In years last birthday) 71 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | | | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOME MAKER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MD. | | | | | | | | | | | | | |
| 13. FATHER'S NAME
SAMUEL EATON | | | 14. MOTHER'S MAIDEN NAME
Ella ? | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-12-6351 | | 17. INFORMANT (Niece) Balto. Md. ADDRESS
Mrs. Catherine Mitchell, 819 S. Montford Ave. | | | | | | | | | | | | | |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">18. 250.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</td> <td colspan="2">CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute renal failure

(B) Septicemia
DUE TO, OR AS A CONSEQUENCE OF:

(C) Diabetic acidosis</td> <td colspan="2">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7 days

4 days

(?)</td> </tr> <tr> <td colspan="6">II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</td> </tr> </table> | | | | | | 18. 250.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute renal failure

(B) Septicemia
DUE TO, OR AS A CONSEQUENCE OF:

(C) Diabetic acidosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7 days

4 days

(?) | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 18. 250.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute renal failure

(B) Septicemia
DUE TO, OR AS A CONSEQUENCE OF:

(C) Diabetic acidosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7 days

4 days

(?) | | | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | |
| 22. I certify that we (this hospital) attended the deceased from May 30 19 69 to May 31 19 69 that we last saw the deceased alive on May 31 19 69 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. we (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
Cezar A. Lopez | | | | 23B. DATE SIGNED
May 31, 1969 | | | | | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Typed)
CEZAR A. LOPEZ M.D. | | 23D. ADDRESS
CHURCH HOME AND HOSP. | | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/4/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Meadowridge Memorial Park | | | | | | | | | | | | | |
| | | 24D. LOCATION (City, town, or county) (State)
Dorsey, Maryland | | | | | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
John E. Taylor M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
John J. Dada, 2829 Hudson St. Balto. Md. | | | | | | | | | | | | | |

X P

ON

95-17-1

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R-200

69 5703 BALTIMORE CITY HEALTH DEPARTMENT

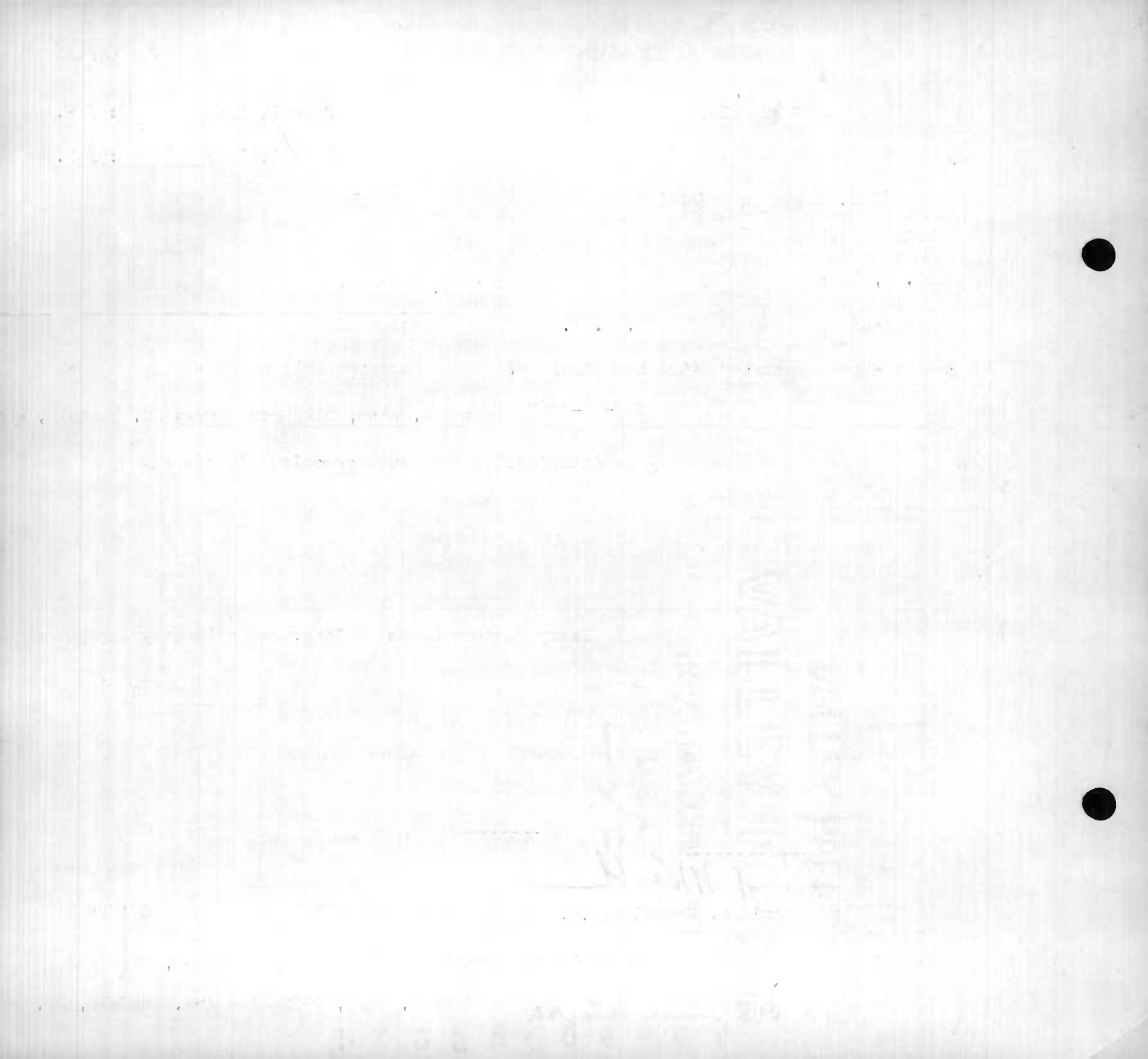
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5703

BIRTH NO.

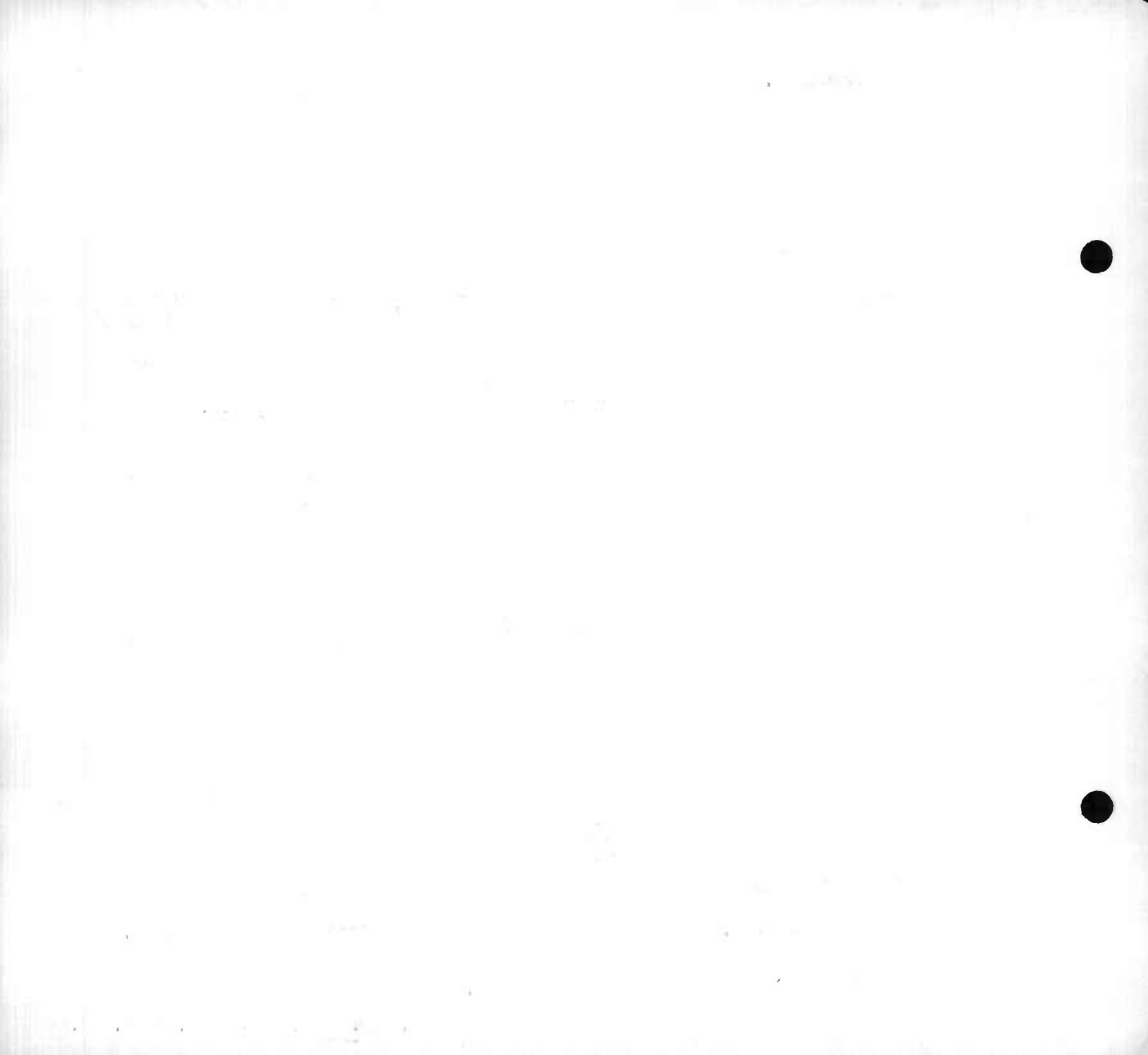
| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
JOSEPH RICE | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 1, 1969
6:05 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
12 S. Robinson (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 1, 1969
6:05 P. M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
Oct. 8, 1905 | | 10. AGE (In years lost birthday) 63
If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Crane Operator | | 14B. KIND OF BUSINESS OR INDUSTRY
Bethlehem Steel Co. | |
| 15. MOTHER'S MAIDEN NAME
Margaret Trigger | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 17. SOCIAL SECURITY NO.
213-07-3562 | | 18. INFORMANT (Son)
Joseph M. Rice, 8113 Park Haven Rd. Dundalk, Md | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
Fatty metamorphosis of liver and pulmonary emphysema | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 22. FATTY METAMORPHOSIS OF LIVER AND PULMONARY EMPHYSEMA | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Ronald N. Kornblum
EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED
6/1/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/5/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Meadowridge Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Dorsey, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 3 1969 | | 25B. NAME OF REGISTRAR
James E. Faber, M.D. | |
| 25C. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

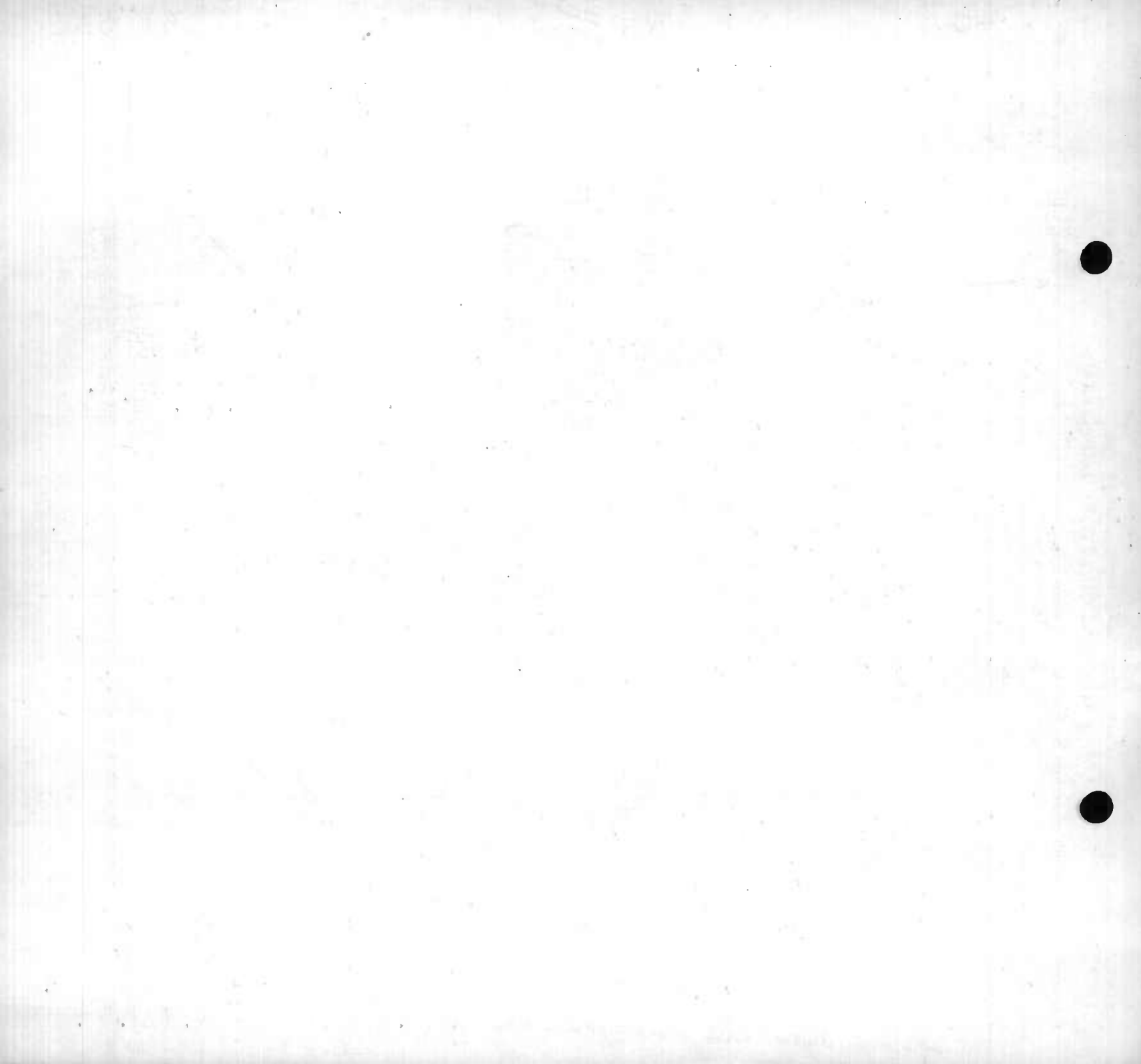
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|--|--|--|
| 69 5704 | | REG. NO. 69 5704 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Antonio T. FERRERI | |
| 2. DATE AND HOUR OF DEATH
5/30/69 8:15 P. M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore | | 5. SEX Male 6. RACE White | |
| C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| E. STREET AND NUMBER 32 Patapsco AVE. | | 8. DATE OF BIRTH 3-2-92 9. AGE (in years last birthday) 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Cefalu, Sicily | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME Joseph FERRERI | | 14. MOTHER'S MAIDEN NAME G. Gondolfa TERNINE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 051-09-5120 | |
| 17. INFORMANT Mary Turchak ADDRESS 2163 East 15th Street Brooklyn, N.Y. 11229 | | 18. CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
41094 2150.9 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Mrs. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF: (suspected) | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerosis, phlebotomy | | years. | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-30 19 69 to 5-30 19 69 that (I) (we) last saw the deceased alive on 5-30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death. | | | |
| 23A. SIGNATURE Philip H. Moore DEGREE | | 23B. DATE SIGNED 5-30-69 | |
| 23C. PHYSICIAN'S NAME (Type) Philip H. Moore DEGREE | | 23D. ADDRESS Mercy Hospital Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 6/2/1969 | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cem. | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR John E. Taylor, M.D. | 25C. FUNERAL DIRECTOR ADDRESS John J. Dudge 7922 Wise Ave. Balt. Md. 21222 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | 69 5705 |
|--|---|---|---|
| BIRTH NO. | | 69 5705 | |
| 1. NAME OF DECEASED
(Type or Print) Agnes M. Kirk
<i>AGNES KIRK</i> | | 2. DATE AND HOUR OF DEATH
5-29-69 8:10pm M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
South Baltimore Gen. Hospital
<i>South Baltimore General Hospital</i> | | C. CITY OR TOWN Dundalk | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER
6816 Bessemer ave. | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-25-25 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
44 |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Wm. Joseph Reuschling | | 14. MOTHER'S MAIDEN NAME
Margaret Mary Martin | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. Yes
220-12-7579 | |
| 17. INFORMANT Husband:
Arthur H. Kirk | | ADDRESS
6816 Bessemer Ave. Balt. Md. 21222 | |
| 18. 174 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Metastatic Cancer Liver, Pancreas | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 months | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Cancer breast RIGHT HT
8 months | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF:
Massive Ascites, Anemia.
2 months | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
HYPOTENSION | | | |
| 19A. DATE OF OPERATION
9-21-68 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cancer Right breast | |
| 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-9-69 to 5-29-69 , that (I) (we) last saw the deceased alive on 5/29/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Abdul G. Qureshi
DEGREE | | 23B. DATE SIGNED
5-30-69 | |
| 23C. PHYSICIAN'S NAME (Type)
ABDUL G. QURESHI
DEGREE | | 23D. ADDRESS
3001 S. HANOVER ST. BALTIMORE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
June 2, 1969 | 24C. NAME OF CEMETERY or CREMATORY
Bel Air Memorial Gardens | 24D. LOCATION (City, town, or county) (State)
Belair (Harford County) Md. |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR
John J. Duda | 25C. FUNERAL DIRECTOR ADDRESS
7922 Wise Ave. Balt. Md. 21222 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

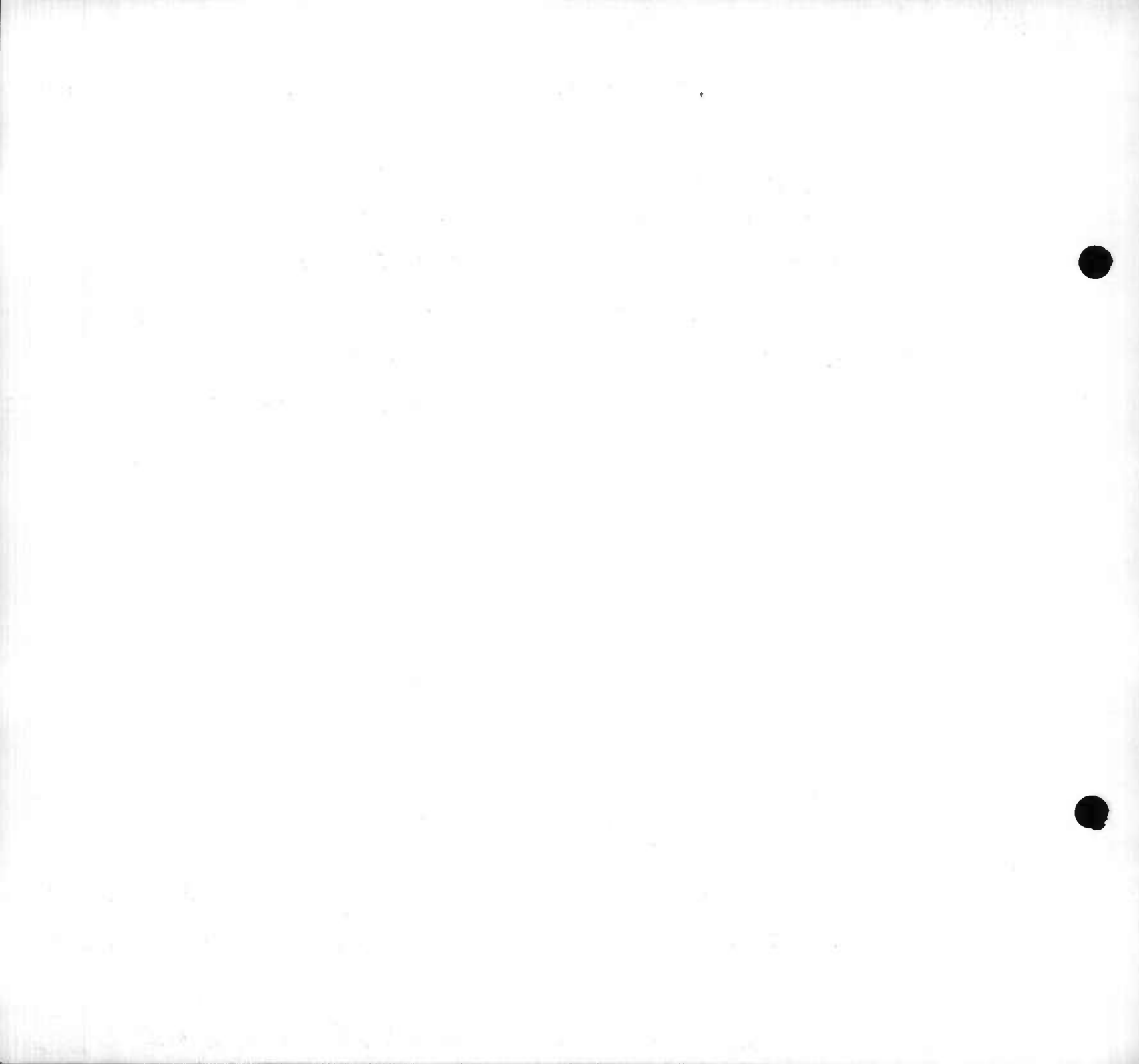
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5706 | |
|---|---------------------|---|-------------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Christopher Johnson</i> | | 2. DATE AND HOUR OF DEATH
<i>6-1-69</i> <i>10 15</i> A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>MD.</i> B. COUNTY <i>12-06</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>37 Mercy Hospital</i> | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER
<i>2303 Maryland Ave</i> | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>11-29-82</i> | 9. AGE in years last birthday
<i>86</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>anemic Care Taker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Norway</i> | |
| 13. FATHER'S NAME
<i>unknown</i> | | 14. MOTHER'S MAIDEN NAME
<i>unknown</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <i>519.2</i> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Respiratory Failure, Ac.</i>
(B) <i>Pulmonary Infarction, Rt.</i>
(C) <i>Chronic Obstructive Lung Disease</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<i>Possible Pneumonia</i> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20. TIME OF INJURY (APPROX.) | | 21. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | |
| 22. I certify that (X) (this hospital) attended the deceased from <i>5/11</i> 19 <i>69</i> to <i>6/1</i> 19 <i>69</i>
that (X) (we) last saw the deceased alive on <i>6/1</i> 19 <i>69</i> and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | (If in Baltimore City, give exact location) | |
| 23A. SIGNATURE
<i>Manuela M. Ribeiro, M.D.</i> | | 23B. DATE SIGNED
<i>6/1/69</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>MANUELA M. RIBEIRO, M.D.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<i>6/4/69</i> | | 24C. NAME OF CEMETERY OR CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 5 1969</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5707</u> | |
|---|-------------------------|---|---|--|--|
| BIRTH NO. <u>69 5707</u> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>FORD, NELLIE I.</u> | | | 2. DATE AND HOUR OF DEATH
<u>JUNE 2, 1969</u> <u>11:00P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>40 ST AGNES HOSPITAL</u>
<u>WILKENS & CATON AVES</u>
<u>BALTIMORE MARYLAND 21229</u> | | | A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| | | | E. STREET AND NUMBER <u>644 ORPINGTON ROAD</u> | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>08 20 87</u> | 9. AGE (In years lost birthday)
<u>81</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SALES</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>REAL ESTATE</u> | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>GEORGE W. FORD</u> | | | 14. MOTHER'S MAIDEN NAME
<u>ANNA HARRISON</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>213542144</u> | 17. INFORMANT <u>BALTO MD</u> ADDRESS
<u>ST AGNES RECORDS-WILKENS & CATON AVES</u> | | |
| 18. <u>438.9 I</u> CAUSE OF DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>(A) IMMEDIATE CAUSE <u>cerebral vascular disease</u></u>
DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>(B) _____</u>
<u>(C) _____</u> | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>21</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>NO YES</u> | | 20A. AUTOPSY? (Yes or No)
<u>NO YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MAY 25</u> 19 <u>69</u> to <u>JUNE 2</u> 19 <u>69</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JUNE 2</u> 19 <u>69</u> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE
<u>A. S. Shams, M.D.</u> | | | | 23B. DATE SIGNED
<u>JUNE 2, 1969</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>A. SHAMS M.D.</u> | | | | 23D. ADDRESS
<u>ST AGNES HOSPITAL WILKENS & CATON AVES</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>6-6-69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>WOODLAWN CEM.</u> | |
| 24D. LOCATION
<u>BALTIMORE MARYLAND</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 5 1969</u> | | | |
| 25B. NAME OF REGISTRAR
<u>2222 E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>WEBER FUNERAL HOME</u> | | ADDRESS <u>5377</u> | |



FUNERAL DIRECTOR: IMPORTANT

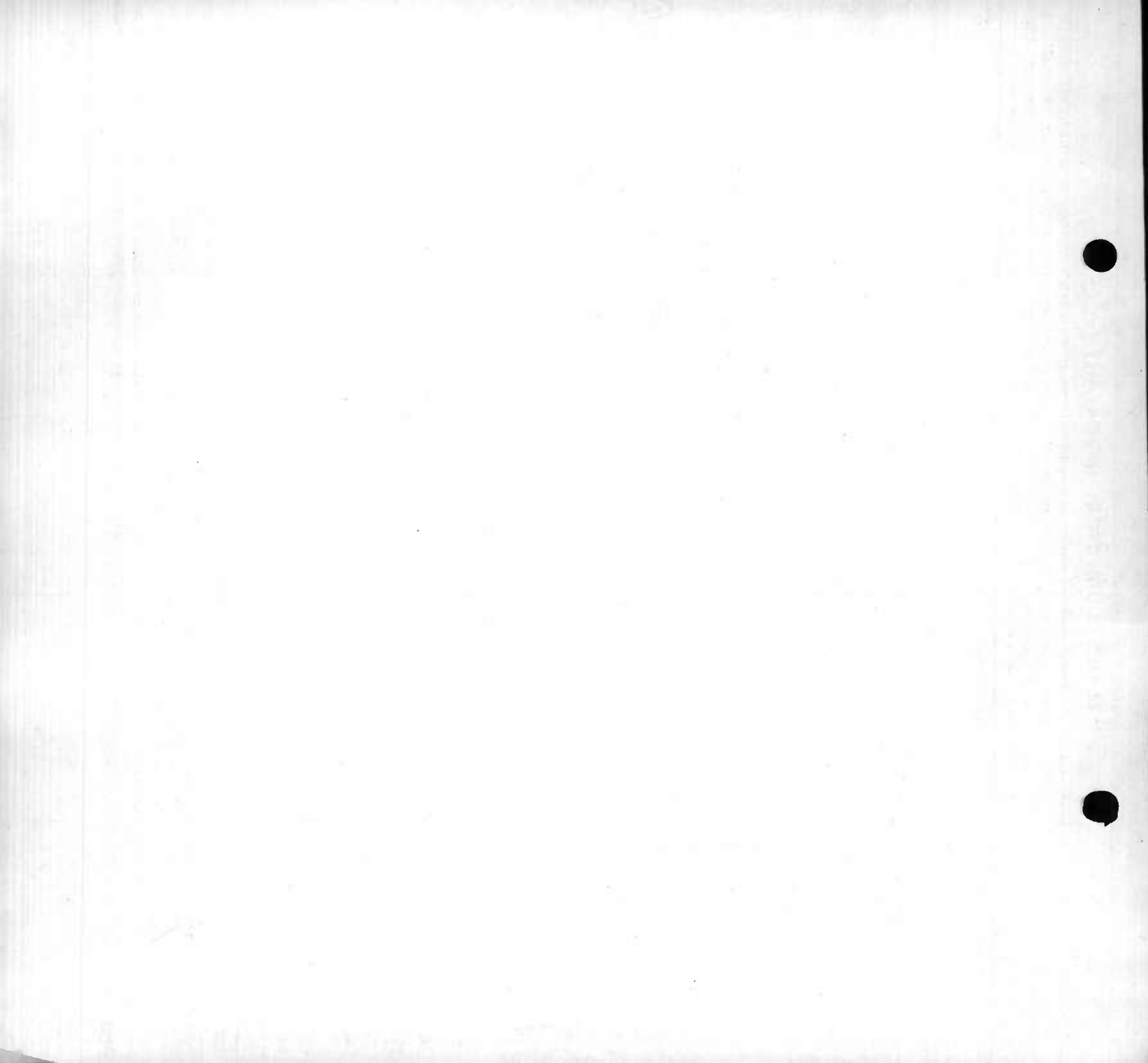
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 5708 CERTIFICATE OF DEATH

REG. NO. 69 5708

| | | | | | |
|--|---------------------|---|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>WILLIAM HARRIS</u> | | 2. DATE AND HOUR OF DEATH
<u>5-30-69</u> <u>6:30 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>BALTIMORE, MD.</u> B. COUNTY <u>12-04</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>FRANKLIN SQUARE HOSPITAL</u> | | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | E. STREET AND NUMBER
<u>306 E. NORTH AVE</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
<u>5-30-69</u> | 9. AGE (In years last birthday)
<u>67</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (State or foreign country)
<u>NEW YORK</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>WILLIAM HARRIS</u> | | | 14. MOTHER'S MAIDEN NAME
<u>MARY</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>294 32 7095A</u> | | 17. INFORMANT
<u>UTAI RUANGWIT, M.D.</u> ADDRESS
<u>FRANKL. SQ. HOSP.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>5-11-94-303.9</u>
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>CARDIOPULMONARY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>PULMONARY TUBERCULOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>ALCOHOLISM</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>II</u> | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>-</u> | | 20A. AUTOPSY? (Yes or No)
<u>-</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<u>-</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>-</u> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
<u>-</u> | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
<u>-</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>-</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5-29-</u> <u>19 69</u> to <u>5-30</u> <u>19 69</u> , that (I) (we) last saw the deceased alive on <u>5-30-</u> <u>19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Utai Ruangwit, M.D.</u> | | | | 23B. DATE SIGNED
<u>5-30-69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>UTAI RUANGWIT, M.D.</u> | | | | 23D. ADDRESS
<u>FANATOMY BOARD OF MARYLAND</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>6/3/68</u> | | 24B. DATE
<u>6/3/68</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>JOHNS HOPKINS MEDICAL SCHOOL</u> | |
| 24D. LOCATION
(City, town, or county) (State)
<u>MORTUARY SERVICE - BCHD</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 5 1969</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>5 6 0 9</u> | | | |



1
L-420

69 5709 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5709

BIRTH NO.

REG. NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
CALVIN H. LYLES | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 1543 Division Street | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
April 28, 1969 6:15 P.M. | |
| 6. SEX
male | | 7. RACE
negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 14-02 | |
| 9. DATE OF BIRTH | | 10. AGE (in years last birthday)
44 | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT | | ADDRESS | |

| | | |
|---|--|--|
| 19. CAUSE OF DEATH
571.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cirrhosis of Liver
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

| | | | | |
|--|--|--|--|--|
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
Yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? |

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Werner U. Spitz, M.D.** M.D.
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **4/29/69**

| | | | | | | | |
|--|--|--|--|------------------------------------|--|---|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
5/29/69 | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
Robert E. Jaber, M.D. | | 25C. FUNERAL DIRECTOR | | ADDRESS | |

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

1 9 6 9 0 0 0 5 7 0 0

James G. [unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5710</u> |
|---|----------------------------|---|----------------------------|--|
| BIRTH NO. <u>69-1949</u> | | 69 5710 CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| LENNON, David Earl | | May 23, 1969 6:00 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital
The John F. Kennedy Institute | | A. STATE
Maryland | | |
| | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
520 S. Macon Street | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
2/4/69 | 9. AGE (In years last birthday)
3 19 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| 13. FATHER'S NAME
John Lennon | | 14. MOTHER'S MAIDEN NAME
Annie Ruth Graham | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
ADDRESS | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. <u>776.9</u> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <u>Cardio-Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>Aspiration</u>
DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="width: 45%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> </div> <div style="width: 50%;"> <p><u>Cornelius De Longe Syndrome</u></p> </div> </div> | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> 19 <u>69</u> to <u>5/23</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/22</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Frank Bowyer M.D.</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>5/23/69</u> |
| 23C. PHYSICIAN'S NAME (Type)
Frank Bowyer, M.D. | | 23D. ADDRESS
The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE
<u>6/2/69</u> | 24C. NAME OF CEMETERY or CREMATORY
ANATOMY BOARD OF MARYLAND | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor M.D.</u> | | 25C. HEALTH DIRECTOR
ADDRESS |
| <div style="display: flex; justify-content: space-between;"> <div> <p>JUN 5 1969</p> </div> <div> <p>57 HOSPITAL DISPOSAL</p> </div> </div> | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5711</u> | |
|---|--|---|--|---|--|
| BIRTH NO. <u>69 5711</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>LEROY JAMES</u> | | 2. DATE AND HOUR OF DEATH
<u>5-29-69</u> <u>6:15</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>3-01</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>35 CHURCH HOME AND HOSPITAL</u> | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>M</u> | | 6. RACE <u>N</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Worked in Bar</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
<u>8-20-10</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | 9. AGE (In years last birthday)
<u>58</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | | 17. INFORMANT ADDRESS | |
| 18. <u>263.9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<u>?? Cerebral Hemorrhage</u> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>48 HRS</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Wernicke Encephalopathy</u>
DUE TO, OR AS A CONSEQUENCE OF: | | <u>5-16 to 5-29</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5-16</u> 19 <u>69</u> to <u>5-29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>5-29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>John F. Miller, Jr.</u> M.D. DEGREE | | | | 23B. DATE SIGNED
<u>5-29-69</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
<u>100 N. Broadway</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>6/3/69</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>JOHNS HOPKINS MEDICAL SCHOOL</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 5 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fairbank, M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>MORTUARY SERVICE - BCHD</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5712</u> |
|---|---------------------|---|---|---|
| 69 5712 | | | | 4 |
| BIRTH NO. <u>69-08977</u> | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Baby Girl BOURNE</u> | | 2. DATE AND HOUR OF DEATH
<u>MAY 25, 1969</u> <u>2⁵⁰ P</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>48 Md Gen. Hosp.</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <u>md.</u> B. COUNTY <u>4-01</u> | | |
| | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
<u>117 W SAKATOGA 21201</u> | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>MAY 25, 1969</u> | 9. AGE (in years last birthday)
<u>2</u> 30 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>md.</u> |
| | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>EVERETTE GAYLE BOURNE</u> | | 14. MOTHER'S MAIDEN NAME
<u>SUZANNE ANITA RAPPELT</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>—</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>Mother</u>
ADDRESS
<u>SAME</u> |
| 18. <u>777 X1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH
<u>Immaturity</u>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

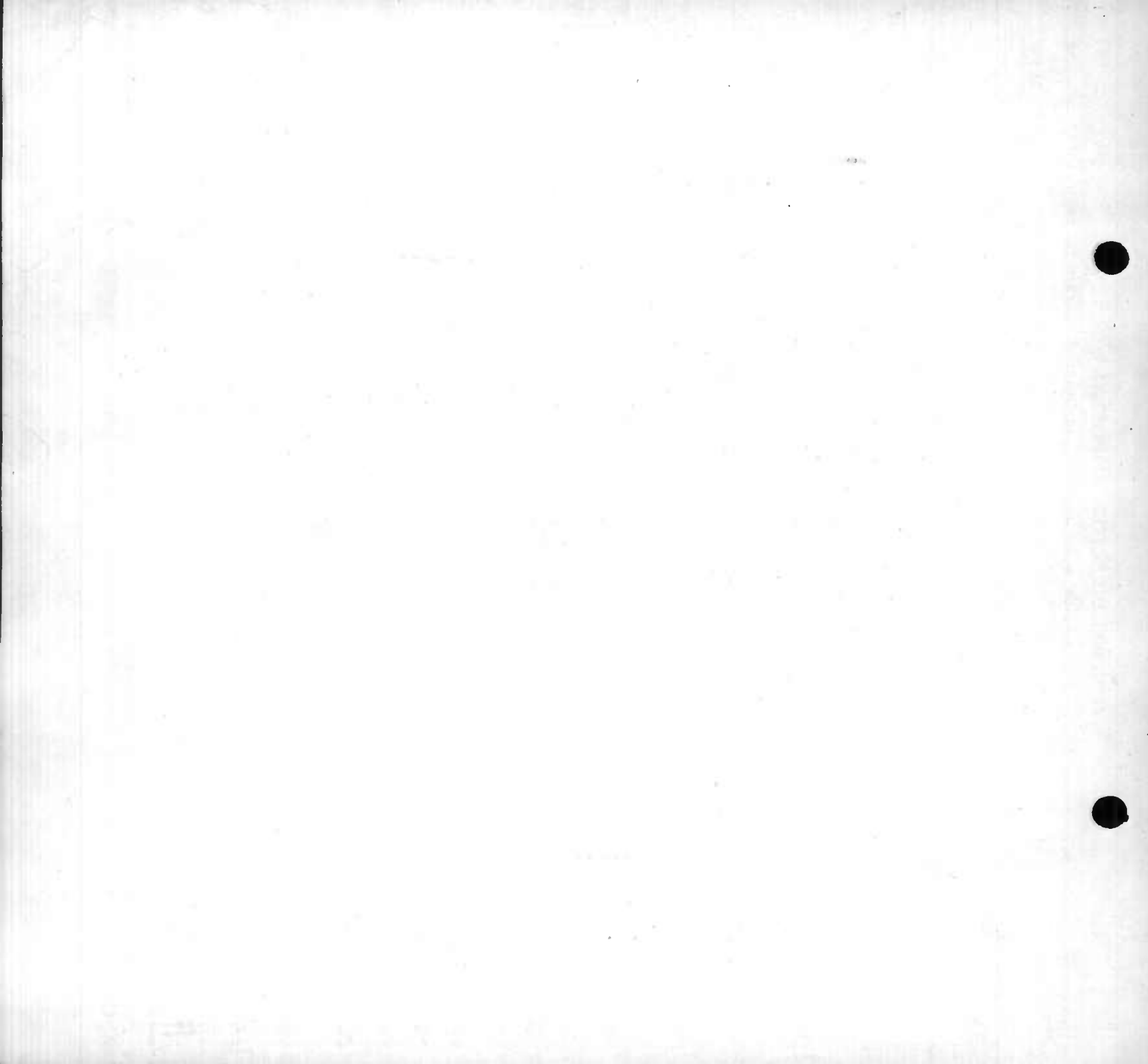
(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>MAY 25</u> 19 <u>69</u> to <u>MAY 25</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>MAY 25</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Migilio G. James</u> | | 23B. DATE SIGNED
<u>5/25/69</u> | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>5/28/69</u> | | 24C. NAME of CEMETERY or CREMATORY |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 5 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u> |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|---------|--|---|--|---|
| P-456 | | 69 5713 | | 69 5713 | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| PALMER, Don A. | | | May 31, 1969 6.30 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| 31 4940 Eastern Ave
Baltimore, Maryland #21224
BALTIMORE CITY HOSPITALS | | | Maryland Baltimore 53-00 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 17 Woodland Ave | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | April 25, 1899 | 70 | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Maintenance man | | Paint | | Penna | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Palmer | | | ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 200-03-8972 | | 4940 Eastern Ave
BCH Records: Baltimore, Maryland #21224 | |
| 18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES | | | Cardio-respiratory arrest | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Terminal carcinomatosis | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| O | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/30/69 19 to 5/31/69 19, that (I) (we) lost saw the deceased alive on 5/31/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| Jose Torres M.D. | | | 5-31-69 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| Jose Torres M.D. | | | 4940 Eastern Ave #21224
Baltimore City Hospitals | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 6/3/69 | | Sacred Heart Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Dundalk, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUN 5 1969 | | Julius E. Taylor, M.D. | | Ulrich Funeral Home Dundalk, Md. | |



FUNERAL DIRECTOR: IMPORTANT

VS 150-REV. 1/1/68

REG. NO. 69 5714

| | | | |
|---|---------------------|---|---|
| BIRTH NO. | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print)
KATIE S. CALLEN | | 2. DATE AND HOUR OF DEATH
MAY 29, 1969 6:50 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 26-33 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
4 UNION MEMORIAL HOSP. | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
3709 BELAIR RD. 21213 | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 2, 1895 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
74 |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
WILLIAM MCCLEARY | | 14. MOTHER'S MAIDEN NAME
REBECCA COLEMAN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
MRS BESSIE RIDGELY-217 BROOKSIDE DR |
| 18. 436.9-4250.9
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ASCVD - DIABETES MELLITUS | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: cardiac - vascular
old Austin Moore prosthesis
(B) old fracture of hip.
DUE TO, OR AS A CONSEQUENCE OF:
(C) | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 15 19 69 to May 29 19 69 that (I) (we) last saw the deceased alive on May 29 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Jose Lito S. Amario M.D. | | 23B. DATE SIGNED
5/29/69 | |
| 23C. PHYSICIAN'S NAME (Type)
JOSELITO S. AMARIO M.D. | | 23D. ADDRESS
Union Memorial Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6/2/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
PARKWOOD CEMETERY | | 24D. LOCATION (City, town, or county) (State)
PARKVILLE MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
Paul S. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
ULSRAH FUNERAL HOME | | ADDRESS
4210 BELAIR RD | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| S-450 | | 69 5715 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | 69 5715 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Schlimme; Harry SAMUEL</u> | | | | 2. DATE AND HOUR OF DEATH
<u>6/1/69</u> <u>6:00 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE
<u>MARYLAND</u> | | B. COUNTY
<u>BALTIMORE</u> | | 53-60 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>31</u>
<u>BALTIMORE CITY HOSPITALS</u>
<u>4940 EASTERN AVENUE</u>
<u>BALTIMORE, MARYLAND #21224</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<u>Sparrows Point</u> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX
<u>MALE</u> | | 6. RACE
<u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>11/ /80</u> | | 9. AGE (In years last birthday) <u>88</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Water tender</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Steel</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>FREDERICK SCHLIMME</u> | | 14. MOTHER'S MAIDEN NAME
<u>EMMA KLINGER</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>2179 01-0414</u> | | 17. INFORMANT
<u>RECORDS: BALTIMORE CITY HOSPITALS</u>
<u>4940 EASTERN AVENUE</u> <u>#21224</u> | |
| 18. <u>154.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<u>PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>CARCINOMA OF RECTUM</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 month</u>
<u>3 yrs</u> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>9/30/68</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Colostomy</u> | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/27</u> 19 <u>68</u> to <u>6/1</u> 19 <u>69</u>
that (I) (we) last saw the deceased alive on <u>6/1</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 23A. SIGNATURE
<u>Robert A. Rosenbaum M.D.</u>
DEGREE | | 23B. DATE SIGNED
<u>6/1/69</u> | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>ROBERT A ROSENBAUM M.D.</u>
DEGREE | | 23D. ADDRESS
<u>4940 EASTERN AVENUE</u> <u>BCH</u> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/4/69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Oak Lawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Colgate, Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 5 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Ulrich Funeral Home Dundalk, Md.</u> | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-4501

69 5716 CERTIFICATE OF DEATH

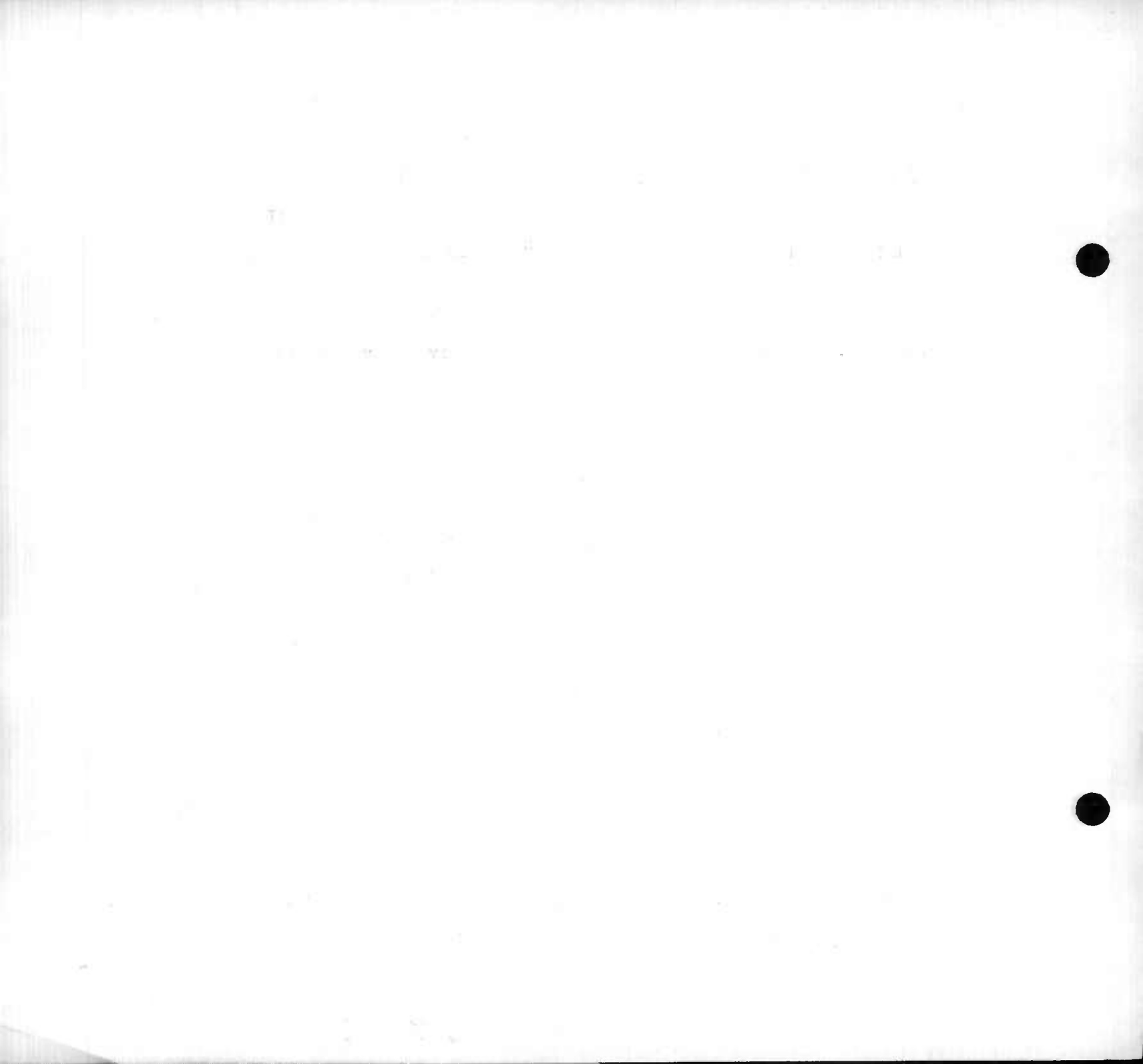
BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 5716

| | | | | | | | |
|--|-------------------------|---|--|---|---|---|--|
| BIRTH NO. | | 69 5716 | | CERTIFICATE OF DEATH | | REG. NO. 69 5716 | |
| 1. NAME OF DECEASED
(Type or Print) <u>T. H. MAS GLENN</u> | | | | 2. DATE AND HOUR OF DEATH
<u>5/30/69 7:00 PM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>33 THE JOHNS HOPKINS HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>TENNESSEE</u>
B. COUNTY <u>V-39</u> | | | |
| | | | | C. CITY OR TOWN
<u>KNOXVILLE</u> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<u>540 FARRAGUT</u> | | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>5-12-62</u> | 9. AGE (In years last birthday)
<u>7</u> | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>School</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Tennessee</u> | |
| 13. FATHER'S NAME
<u>JAKE L. GLENN</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>NANCY MAYS BROWN</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No.</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>Stevens Mortuary, Knoxville, Tenn.</u> | |
| 18. <u>746.21</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>RENAL FAILURE, METABOLIC IMBALANCE</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) <u>ANOXIC ARREST, HEMOLYSIS</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 h</u>
<u>10 h</u>
<u>3 h</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>TETROLOGY OF FALLOT</u> | | | | | | | |
| 19A. DATE OF OPERATION
<u>5/26/69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>TETROLOGY OF FALLOT</u> | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>No</u> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
<u>No</u> | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
<u>No</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>No</u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/26</u> 19 <u>69</u> to <u>5/30/69</u> 19 <u>69</u>
that (I) (we) last saw the deceased alive on <u>5/30/69</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Frederick A. Matsen III, M.D.</u> | | | | 23B. DATE SIGNED
<u>5/30/69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>FREDERICK A. MATSEN III</u> | |
| 23D. ADDRESS
<u>MD JHH</u> | | | | 23E. ADDRESS
<u>JHH</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/3/69</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Lynnhurst Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Knoxville, Tenn.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 5 1969</u> | | 25B. NAME OF REGISTRAR
<u>L. E. J. J. J.</u> | | 25C. FUNERAL DIRECTOR
<u>Ulrich Funeral Home</u> | | ADDRESS
<u>4210 Belair Road.</u> | |



B-460

69 5717 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5717

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
MARY BLAIR | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> 5 31 69 7:45 p. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 4201 Seidel Ave. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 31, 1969 7:45 p. M. | |
| 6. SEX
Female | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 26-42 | |
| 9. DATE OF BIRTH
May 4, 1875 | | 10. AGE (In years lost birthday)
94 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY
U.S.A. | |
| 13. FATHER'S NAME
John Link | | 14. MOTHER'S MAIDEN NAME
Mary Hummel | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At home | | 16. KIND OF BUSINESS OR INDUSTRY | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 18. SOCIAL SECURITY NO.
217-54-3037 | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
412.4
Arteriosclerotic cardiovascular disease | | 20. CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 21. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | |
| 23. DATE OF OPERATION
0 | | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 25. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 26. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | |
| 27. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 28. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 29. HOW DID INJURY OCCUR? | | 30. AUTOPSY? (Yes or No)
No | |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Edward F. Wilson
EXAMINER'S NAME (Type)
Edward F. Wilson, M.D. | | DATE SIGNED
June 1, 1969 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/5/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
Ullrich Funeral Home | | 25D. ADDRESS
4210 Belair Road. | |

W/A

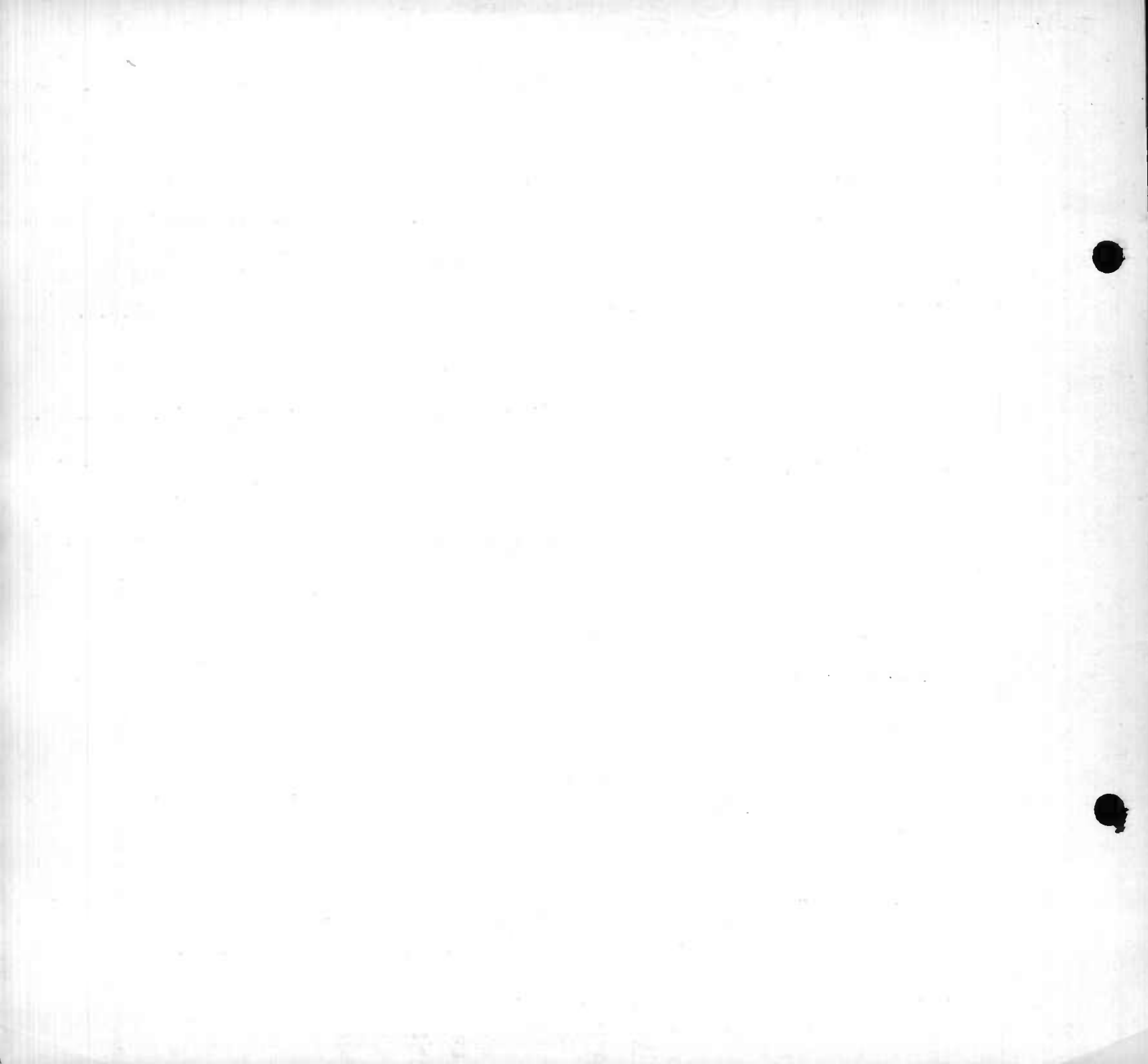
2/11/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 52-37-12 djs | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5718 |
|--|----------------------|---|--------------------------------|--|
| BIRTH NO. <u>W-463</u> | | 69 5718 | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) <u>WOOLRIDGE, SAMUEL T</u> | | 2. DATE AND HOUR OF DEATH
<u>5-29-69</u> <u>7:30 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>BALTIMORE CITY HOSPITALS</u>
<u>4940 EASTERN AVENUE</u>
<u>BALTIMORE, MARYLAND 21224</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>3-02</u>
C. CITY OR TOWN <u>BALTIMORE</u>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>811 E. BALTIMORE STREET 21205</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>7-7-13</u> | 9. AGE (In years last birthday) <u>55</u>
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>lesman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Photography</u> | | 11. BIRTHPLACE (State or foreign country)
<u>VIRGINIA</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>THOMAS</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>MARGARET GILLOCK</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO.
<u>226-05-3069</u> | | 17. INFORMANT
<u>BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>LIVER FAILURE</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 DAYS</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>CIRRHOSIS</u> | | DUE TO, OR AS A CONSEQUENCE OF:
<u>5 YRS.</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>LUNG TUMOR</u> | | <u>?</u> | | |
| 19A. DATE OF OPERATION
<u>5-13 & 5-21</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>(1) CIRRHOSIS (2) ILIUS</u> | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>YES</u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>4-25-69</u> to <u>5-29-69</u> , that (I) (we) last saw the deceased alive on <u>5-28-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | |
| 23A. SIGNATURE
<u>William E. Powers Jr MD</u> | | 23B. DATE SIGNED
<u>5-29-69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>WILLIAM E. POWERS JR MD</u> |
| 23D. ADDRESS
<u>BALTIMORE CITY HOSPITALS</u>
<u>4940 EASTERN AVE. BALTO. MD. 21224</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | |
| 24B. DATE
<u>6/1/69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Nat. Memorial Park</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Falls Church, Va</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 5 1969</u> | | 25B. NAME OF REGISTRAR
<u>James E. Jaber, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>R. A. Pumphrey, Bethesda, Md.</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

| BIRTH NO. 69 5719 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5719 | |
|--|-------------------------|---|---|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) Barbagallo, Tony | | | | 2. DATE AND HOUR OF DEATH
6.1.69 6 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
48 Maryland General Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Prince Georges
C. CITY OR TOWN Linthicum Hgts. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 627 Gayle Ave | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1893
01.22.96 | | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Presser | | 10B. KIND OF BUSINESS OR INDUSTRY
Dress Co. | | 11. BIRTHPLACE (State or foreign country)
Italy. | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
Ciiovanni Barbagallo | | | 14. MOTHER'S MAIDEN NAME
Guiseppi Puglisi | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
067-22-6338 | | 17. INFORMANT
wife | | |
| 18. 185X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

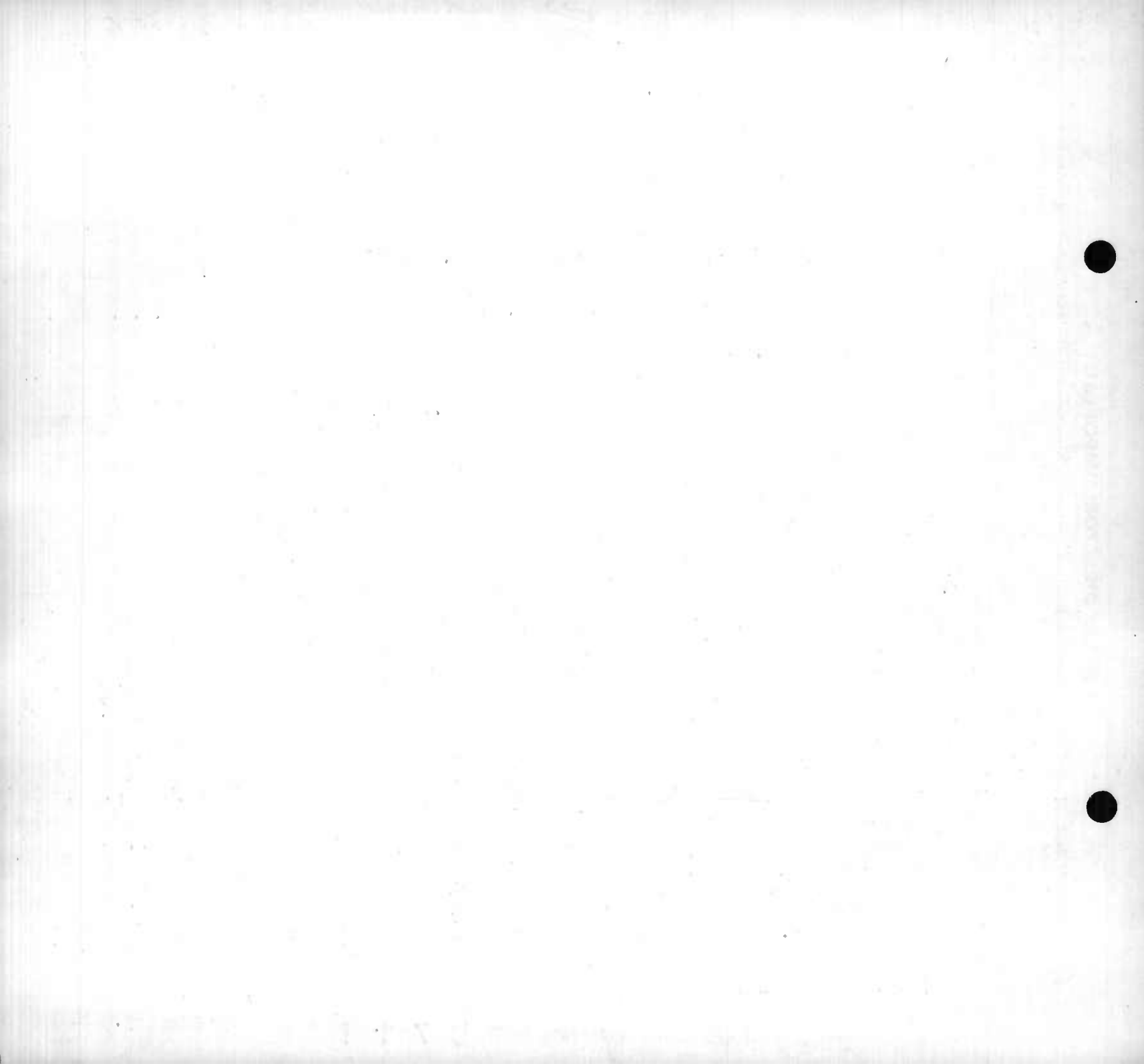
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Hypertensive cardiovascular disease - years | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Left Hemiplegia
(B) carcinoma Prostate with
DUE TO, OR AS A CONSEQUENCE OF:
widespread metastases
(C) months | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 days | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5.12.1969 to 6.1.1969 , that (I) (we) last saw the deceased alive on 6.1.1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Mohammed Sidip | | | | 23B. DATE SIGNED
6.1.69 | | 23C. PHYSICIAN'S NAME (Type)
MOHAMMAD SIDIP M.B.B.S. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-4-69 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Cross | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
J. E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
George J. Gonce | | ADDRESS
4001 Ritchie Hgy. 21225 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|----------------------|--|--|--|--|--|--|---|--|
| 69 5720 CERTIFICATE OF DEATH | | | | | REG. NO. 69 5720 | | | | |
| BIRTH NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Charles J. Bury</u> | | | | | June 1, 1969 M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>South Baltimore General Hospital</u>
<u>43</u> | | | | | A. STATE <u>Maryland</u> | | B. COUNTY <u>Anne Arundel</u> | | |
| | | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| E. STREET AND NUMBER <u>337 Arundel Road</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan. 25, 1891</u> | | 9. AGE (In years last birthday) <u>78</u> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Time Keeper</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Joseph R. Bury</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>-----</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-05-9038A</u> | | 17. INFORMANT <u>Mr. Joseph Bury</u> | | ADDRESS <u>Same</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>410.9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Acute Myocardial Infarction</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Arteriosclerotic heart disease</u> | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Acute Myocardial Infarction</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<u>Arteriosclerotic heart disease</u>
(C) ----- | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Bronchial asthma</u>
<u>emphysema</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1969</u> to <u>5/27</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/27</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Lester Lebo</u> | | | | | 23B. DATE SIGNED | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Lester Lebo</u> | | | | | 23D. ADDRESS <u>719 Med. Arts Bldg</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>6-1-69</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Holy Cross</u> | | 24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> | | (State) <u>Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1969</u> | | 25B. NAME OF REGISTRAR <u>George J. Gpnce</u> | | 25C. FUNERAL DIRECTOR <u>George J. Gpnce</u> | | ADDRESS <u>4001 Ritchie Hgwy. 21225</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5721

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Carmela M. Messina

2. DATE AND HOUR OF DEATH

June 3, 1969

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2029 Whistler Avenue

Morrell Park

Baltimore, Maryland 21230

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

2029 Whistler Avenue 21230

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3-28-1915

9. AGE (In years
last birthday)

54

If Under 1 Yr.
Months: Days:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U, S. A.

13. FATHER'S NAME

Paul Salamone

14. MOTHER'S MAIDEN NAME

Nancy Tezzo

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-05-6034

17. INFORMANT

ADDRESS

21230

Salvatore R. Messina 2029 Whistler Ave.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Cause of colon

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

7 months

(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

about 7 years ago

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Cause of colon

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

5-19 1969 to

6-3 1969

that (I) (we) last saw the deceased alive on

6-2 1969

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Cesar J. Pellerano

DEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

6-3-69

23C. PHYSICIAN'S
NAME (Type)

Cesar J. Pellerano

DEGREE

23D. ADDRESS

2436 Washington Blvd.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-6-69

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore, Maryland

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 5 1969

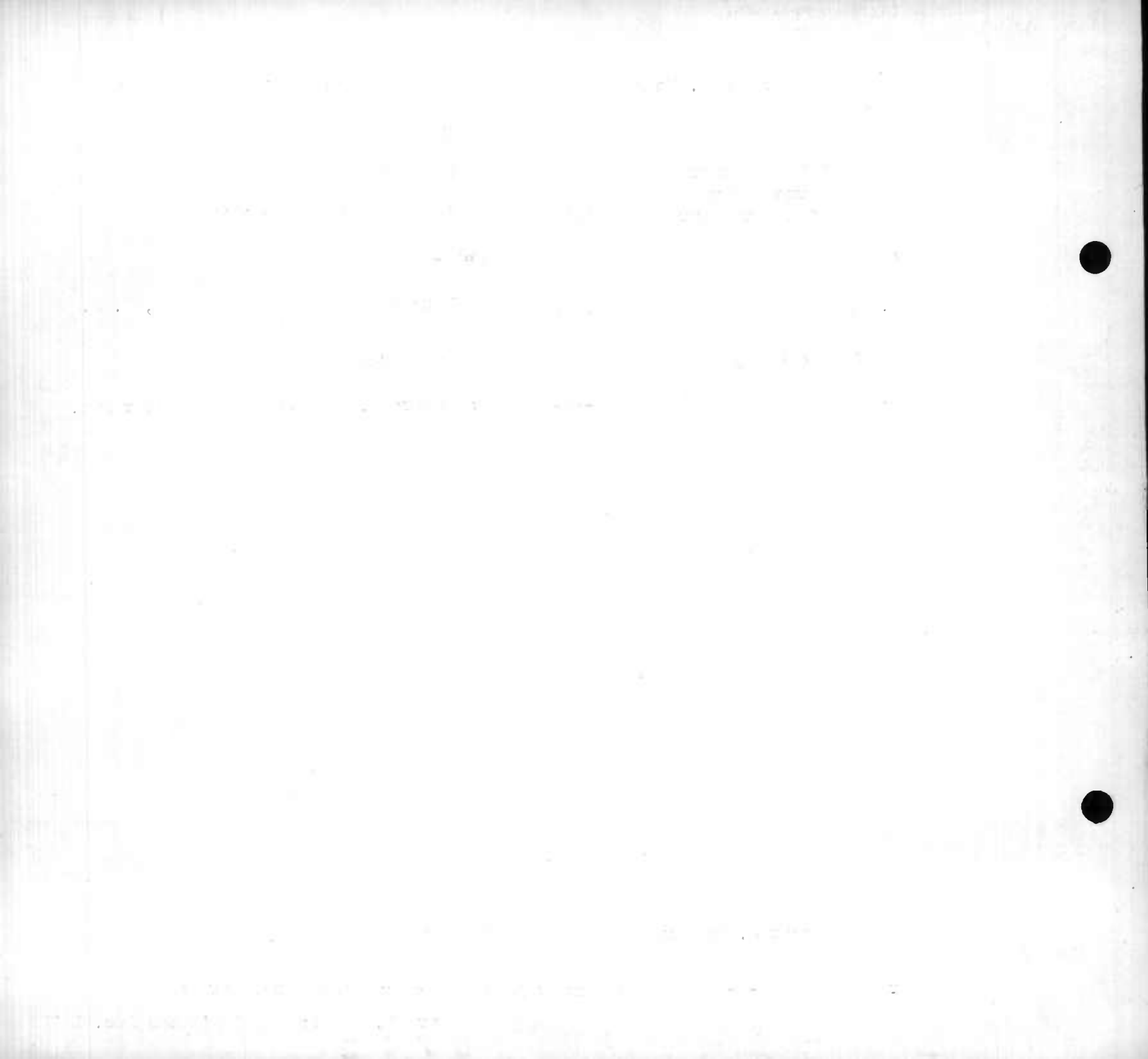
25B. NAME OF REGISTRAR

James E. Taylor, R.D.

25C. FUNERAL DIRECTOR

Howard H. Hubbard 4107 Wilkens Ave. 21229

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 5722 CERTIFICATE OF DEATH

REG. NO. 69 5722

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

George H. Carter

2. DATE AND HOUR OF DEATH

5-31-69

8:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital
Caton & Wilkens Avenue
Baltimore, Maryland 21229

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

704 Manchester Road

5. SEX

Male

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

April 21, 1903

9. AGE (in years last birthday)

66

If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry C. Carter

14. MOTHER'S MAIDEN NAME

Florence Teuffel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

219-40-4446

17. INFORMANT

ADDRESS

Mrs. Helen M. Carter, 704 Manchester Rd. 21229

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1961 to May 31, 1969 that (I) (we) last saw the deceased alive on May 24, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Earl Pass

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

6-2-69

23C. PHYSICIAN'S NAME (Type)

Dr. I. Earl Pass

23D. ADDRESS

4001 Wilkens Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-3-1969

24C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Woodlawn, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUN 5 1969

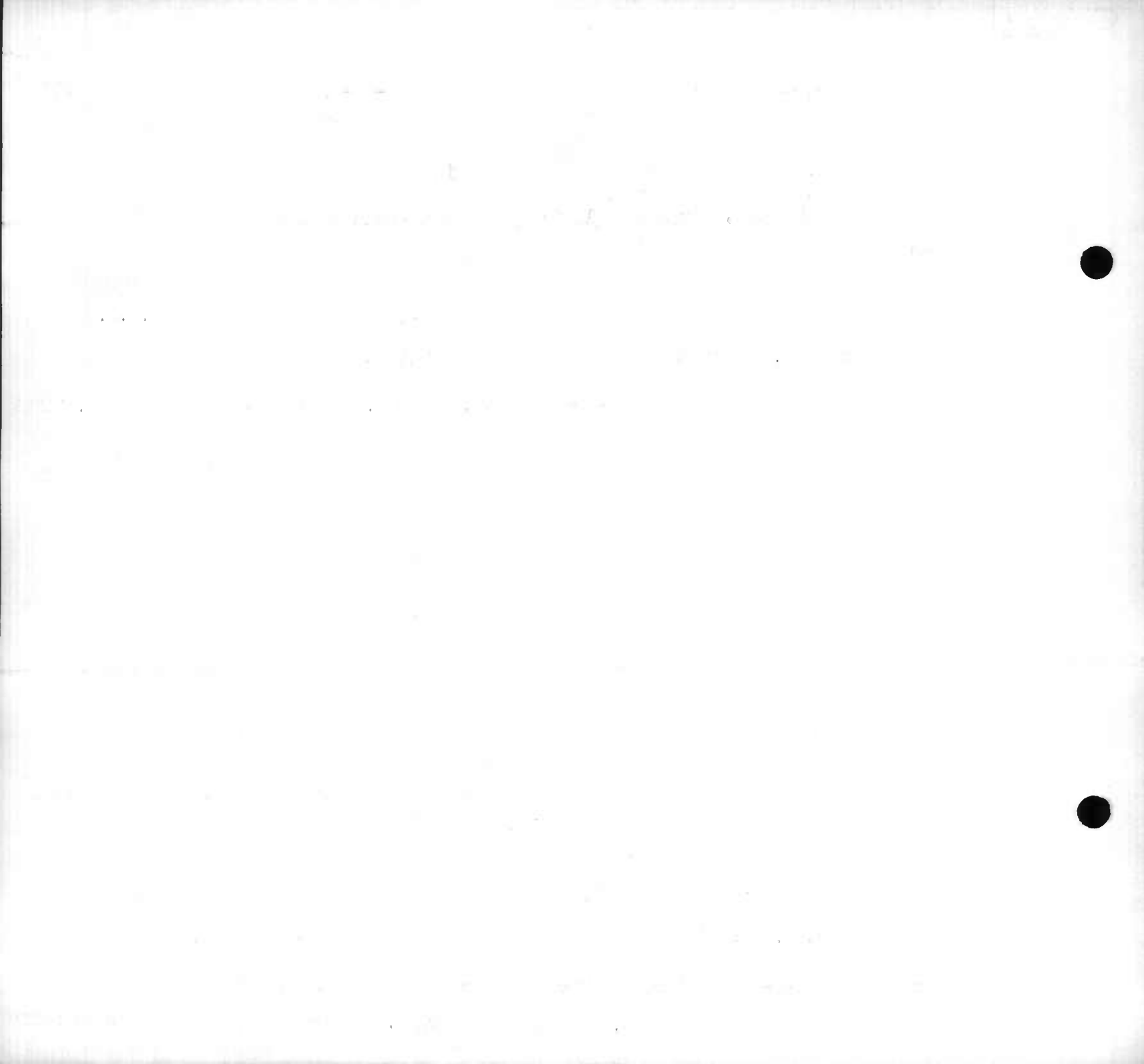
25B. NAME OF REGISTRAR

James E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Avenue 21229

ADDRESS

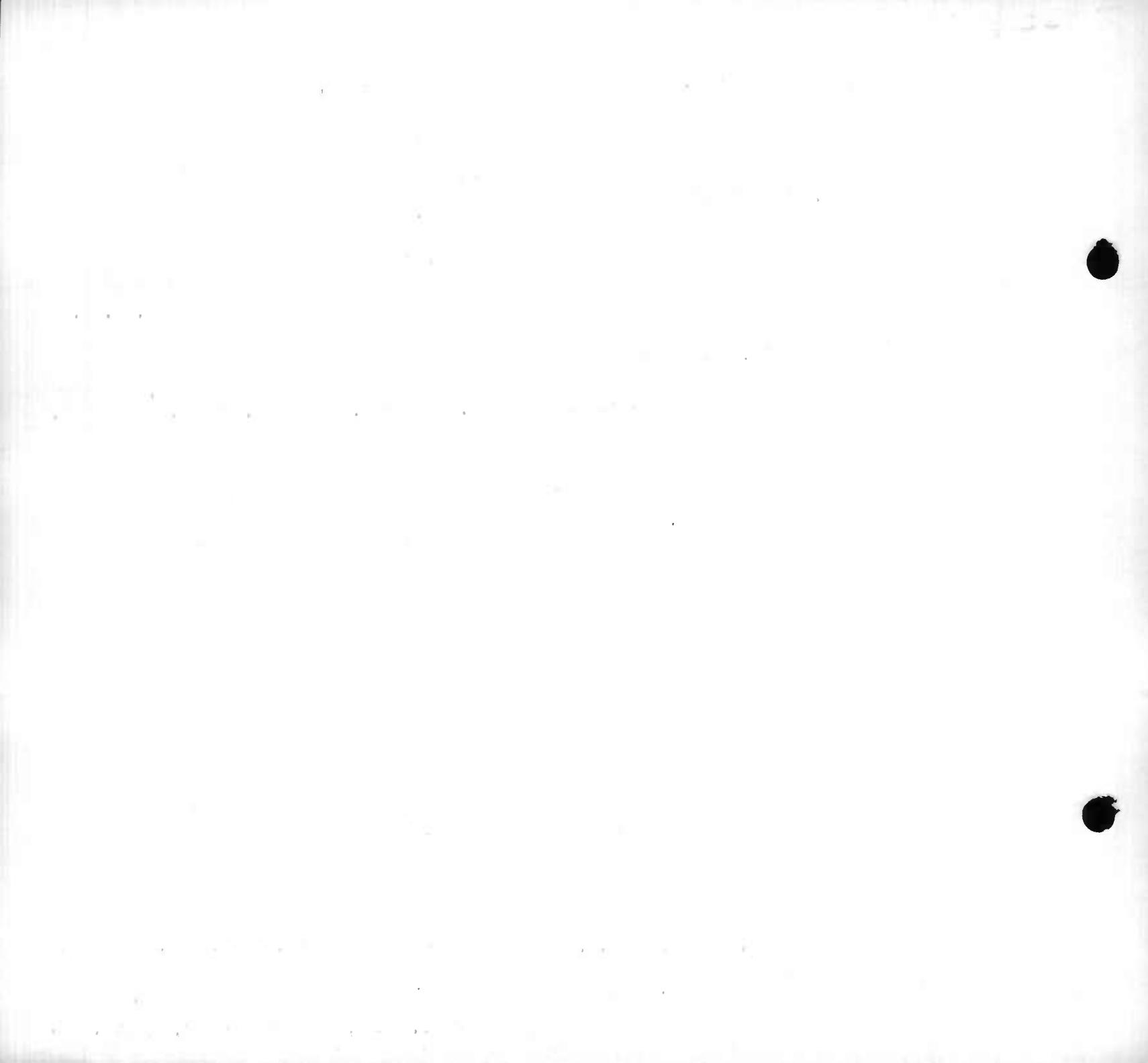


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 69 5723 |
|--|---|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Maryanna S. Zaras | | 2. DATE AND HOUR OF DEATH
June 2, 1969 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

00 125 S. Curley Street | | A. STATE Maryland
B. COUNTY 1-02 | | |
| | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
125 S. Curley Street | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 4, 1919 | 9. AGE (In years lost birthday)
49 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 13. FATHER'S NAME
Michael Dembowczyk (Dembow) | | 14. MOTHER'S MAIDEN NAME
Maryanna Korolewski | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-12-7555 | | 17. INFORMANT (Husband) Baltimore, Maryland
Mr. Joseph F. Zaras Sr. 125 S. Curley St. |
| 18. 1748 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE Metastatic carcinoma 9 mos
DUE TO, OR AS A CONSEQUENCE OF: carcinoma
(B) Carcinoma of breast 1967
DUE TO, OR AS A CONSEQUENCE OF:
(C) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 1967 19 to Feb 14 1969
that (I) (we) last saw the deceased alive on Feb 14 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Charles C. MacMinn M.D. | | 23B. DATE SIGNED
6/3/69 | | 23C. ADDRESS
2900 E. Baltimore St. Baltimore, Maryland |
| 23D. PHYSICIAN'S NAME (Type)
Charles C. MacMinn M.D. | | 23E. ADDRESS
2900 E. Baltimore St. Baltimore, Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/6/69 | | 24C. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cemetery |
| 24D. LOCATION
Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
Robert E. Jaben, M.D. | | 25C. FUNERAL DIRECTOR
John J. Duda |
| | | | | ADDRESS
2829 Hudson St. Balto. Md. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 5724 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 69 5724 | |
|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) Ethel Norr | | | | 2. DATE AND HOUR OF DEATH
June 2, 1969 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
Church Home & Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Church Home & Hospital | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
11/3/05 | | 9. AGE (In years last birthday)
64 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
West Virginia | |
| 13. FATHER'S NAME
William C Redden | | | | 14. MOTHER'S MAIDEN NAME
Bertha Boley | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
233-22-7995 | | 17. INFORMANT (Daughter) Westbury, New York 11590
Mrs. Maxine Kitarogers, 22 Northcote Rd. | |
| 18. 1950 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) IMMEDIATE CAUSE
possibly Hepatic Coma
DUE TO, OR AS A CONSEQUENCE OF:
(B) she lived 3 years
DUE TO, OR AS A CONSEQUENCE OF:
(C) possible intra abdominal malignancy | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/17/1969 to 6/2 19 69 , that (I) (we) last saw the deceased alive on 6/2 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Tarique Alan Furzevi | | | | 23B. DATE SIGNED
June 2, 1969 | | 23C. PHYSICIAN'S NAME (Type)
TARIQUE ALAN FURZEVI | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
6/5/69 | | 24C. NAME OF CEMETERY or CREMATORY
Oak Lawn Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | | | 25B. NAME OF REGISTRAR
Robert E. [Signature] | | 25C. FUNERAL DIRECTOR
John J. Duda | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | 25D. ADDRESS
7922 Wise Ave. Dundalk, Md. | | | |

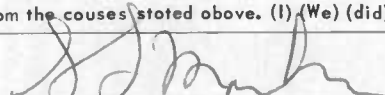
10

Index

Handwritten

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print)
JOHN AGOETZ | | 2. DATE AND HOUR OF DEATH
6/31/69 6:30 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
SOUTH BALTIMORE GENERAL
43 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MD B. COUNTY 25-34 | |
| 5. SEX
♀ | | 6. RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Shop Supt | | 10B. KIND OF BUSINESS OR INDUSTRY
Gross Lab | | 8. DATE OF BIRTH
Aug 1, 1899 | |
| 13. FATHER'S NAME
Samuel Goetz | | 14. MOTHER'S MAIDEN NAME
Wilhemina Muesel | | 9. AGE (In years last birthday)
69 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE | |
| 17. INFORMANT
Mrs Estelle M Goetz | | ADDRESS
3460-6th St 21225 | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 18. 199.0 I CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
metastasis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
CANCER METABOLIC DYSFUNCTION | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
TRACHEOSTOMY | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/11/66 19 to 6/31 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
DEGREE | | | | 23D. ADDRESS
DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/6/69 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Olivet Cem | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore City Md | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | | |
| 25B. NAME OF REGISTRAR
W. S. Jones, M.D. | | 25C. FUNERAL DIRECTOR
McGee, F.H. 737 Paterson ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|--|-------------------------|---|---|---|----------------------------|--|-----------------------------|--|--|
| BIRTH NO. | | 69 5726 | | BALTIMORE CITY HEALTH DEPARTMENT | | 69 5726 | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) <i>Edward Frederick Miller</i> | | | | 2. DATE AND HOUR OF DEATH
<i>May 31, 1969</i> <i>6 P.</i> M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Mt. Sinai Nursing Home</i> | | | | A. STATE
<i>Maryland</i> | | B. COUNTY
<i>Baltimore Co.</i> | | C. CITY OR TOWN
<i>Pockeysville</i> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>90</i> | | | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | E. STREET AND NUMBER
<i>10819 Hollow Road</i> | | F. ZIP CODE
<i>53-00</i> | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Feb. 17, 1879</i> | 9. AGE (In years lost birthday)
<i>90</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Painting Contractor-ret. Self employed</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Penna.</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | |
| 13. FATHER'S NAME
<i>Unknown</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Unknown</i> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>None</i> | | | 17. INFORMANT
<i>Family records</i> | | | |
| 18. <i>412.41</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
<i>Cerebral Hemorrhage</i>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Arteriosclerotic C-v disease</i>
(B) <i>Hypertension</i>
DUE TO, OR AS A CONSEQUENCE OF:
<i>Brain Infection</i>
(C) <i>Brain Infection</i> | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>May 1</i> 19 <i>69</i> to <i>May 31</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>May 30</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>Louis T. Lavy M.D.</i> | | | 23B. DATE SIGNED
<i>June 2 1969</i> | | | 23C. PHYSICIAN'S NAME (Type)
<i>LOUIS T. LAVY</i> | | | |
| 23D. ADDRESS
<i>3502 W. Ross Ave Baltimore Md.</i> | | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 24B. DATE
<i>Jun. 3, 1969</i> | | | |
| 24C. NAME OF CEMETERY or CREMATORY
<i>Falls Road Chapel Cemetery</i> | | | 24D. LOCATION (City, town, or county) (State)
<i>Butler, Balto. Co., Maryland</i> | | | 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 5 1969</i> | | | |
| 25B. NAME OF REGISTRAR
<i>John E. Jones, M.D.</i> | | | 25C. FUNERAL DIRECTOR
<i>John Birnst Sons, Towson, Maryland</i> | | | | | | |

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in the form of a letter, dated 18th June 1891, from the
Joint Committee, London, to the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5727 | |
|---|---------|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> C-455 69 5727 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Edward Coleman | | 5/25/69 5:05 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| Lincoln Memorial Nursing Home | | | Maryland 3-02 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 1123 E. Pratt St | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | Negro | | 6-2-88 | 78 | Unknown |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| | | | | | U.S.A |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME | | |
| | | | | | |
| 14. MOTHER'S MAIDEN NAME | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| | | | 16. SOCIAL SECURITY NO. | | |
| | | | 30-070573-790 | | |
| 17. INFORMANT | | | ADDRESS | | |
| | | | | | |
| 18. CAUSE OF DEATH | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>18. 153.8 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>C.A. of Colon</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> </div> <div> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-4-69 to 5/25/69, that (I) (we) last saw the deceased alive on 5/25/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| [Signature] | | | | 5/25/69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| | | | | 2425 E. Pratt Place | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF BOARD OF MORTUARY SERVICE | |
| | | 6/6/69 | | ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. ADDRESS | |
| JUN 5 1969 | | Robert E. Taylor, M.D. | | MORTUARY SERVICE - BCHC | |

FUNERAL DIRECTOR: IMPORTANT

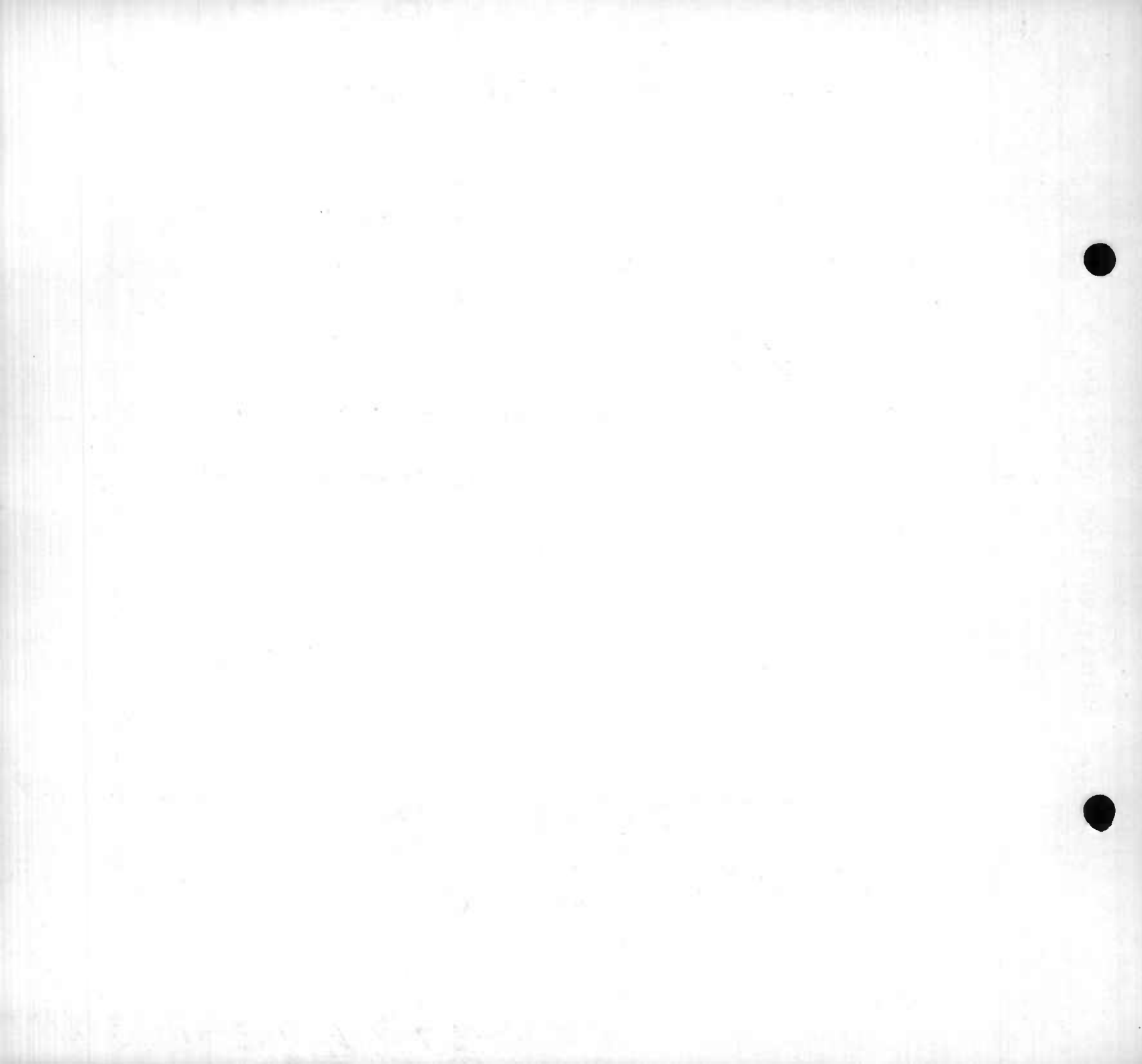
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5728 **CERTIFICATE OF DEATH** REG. NO. 69 5728

| | | | | | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Elizabeth G Smith</i> | | 2. DATE AND HOUR OF DEATH
<i>June 2 1969 10⁰⁰ A.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

<i>003662 Falls Rd</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Md</i> B. COUNTY <i>13-48</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>3662 Falls Rd</i> | | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>April 14 1893</i> | 9. AGE (In years lost birthday) <i>76</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Md</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 13. FATHER'S NAME
<i>John H Miller</i> | | 14. MOTHER'S MAIDEN NAME
<i>Elizabeth K Schneider</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>212 10 7228</i> | | 17. INFORMANT
<i>E. Katherine Collins</i> ADDRESS <i>2bove</i> | |
| 18. <i>174X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Cancer of breast</i>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 yrs</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>1963</i> to <i>June 2 1969</i> , that (I) (we) last saw the deceased alive on <i>June 1 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
<i>Wm J Helfrich</i> DEGREE | |
| 23B. DATE SIGNED
<i>June 3-69</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>Wm J Helfrich</i> DEGREE | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Buried</i> | | 24B. DATE
<i>June 5 1969</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Druid Ridge Cem</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Pikesville Balto Co Md</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 5 1969</i> | | 25B. NAME OF REGISTRAR
<i>John E. Talbot, M.D.</i> | |
| 25C. FUNERAL DIRECTOR
<i>Baroque Funeral Home</i> | | 25D. ADDRESS
<i>Baltimore Md</i> | | 25E. SIGNATURE
<i>Baroque Funeral Home</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 69 5729 |
|--|------------------|---|---------------------------------|---|---|
| BIRTH NO. | | 69 5729 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | Charles Milton Connor | | 2. DATE AND HOUR OF DEATH
June 1 1969 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION
The Wesley Home Inc | | A. STATE
Maryland | | B. COUNTY
27-55 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
90 2211 W Rogers Ave | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
2211 W Rogers Ave | | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov 12 1891 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Office Worker Dairy | | 10B. KIND OF BUSINESS OR INDUSTRY
DAIRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Charles H Connor | | 14. MOTHER'S MAIDEN NAME
Fannie Barrett | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
217032633 | | 17. INFORMANT
Wesley Home Records | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
1858 I | | CAUSE OF DEATH
Carcinoma of Prostate | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: With Metastases | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 7 19 67 to June 1 19 69, that (we) last saw the deceased alive on June 1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Clarence W. LeDoux M.D. | | 23B. DATE SIGNED
6/3/69 | | 23C. PHYSICIAN'S NAME (Type)
Clarence W. LeDoux, M.D. | |
| 23D. ADDRESS
3023 Eastern Ave. Baltimore Md. | | 23E. ADDRESS
3023 Eastern Ave. Baltimore Md. | | 23F. ADDRESS
3023 Eastern Ave. Baltimore Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
June 4 69 | | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore Mt. Cem | |
| 24D. LOCATION
Baltimore Md | | 24E. LOCATION
Baltimore Md | | 24F. LOCATION
Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
J. E. E. M.D. | | 25C. FUNERAL DIRECTOR
Burgess Funeral Home Baltimore Md | |

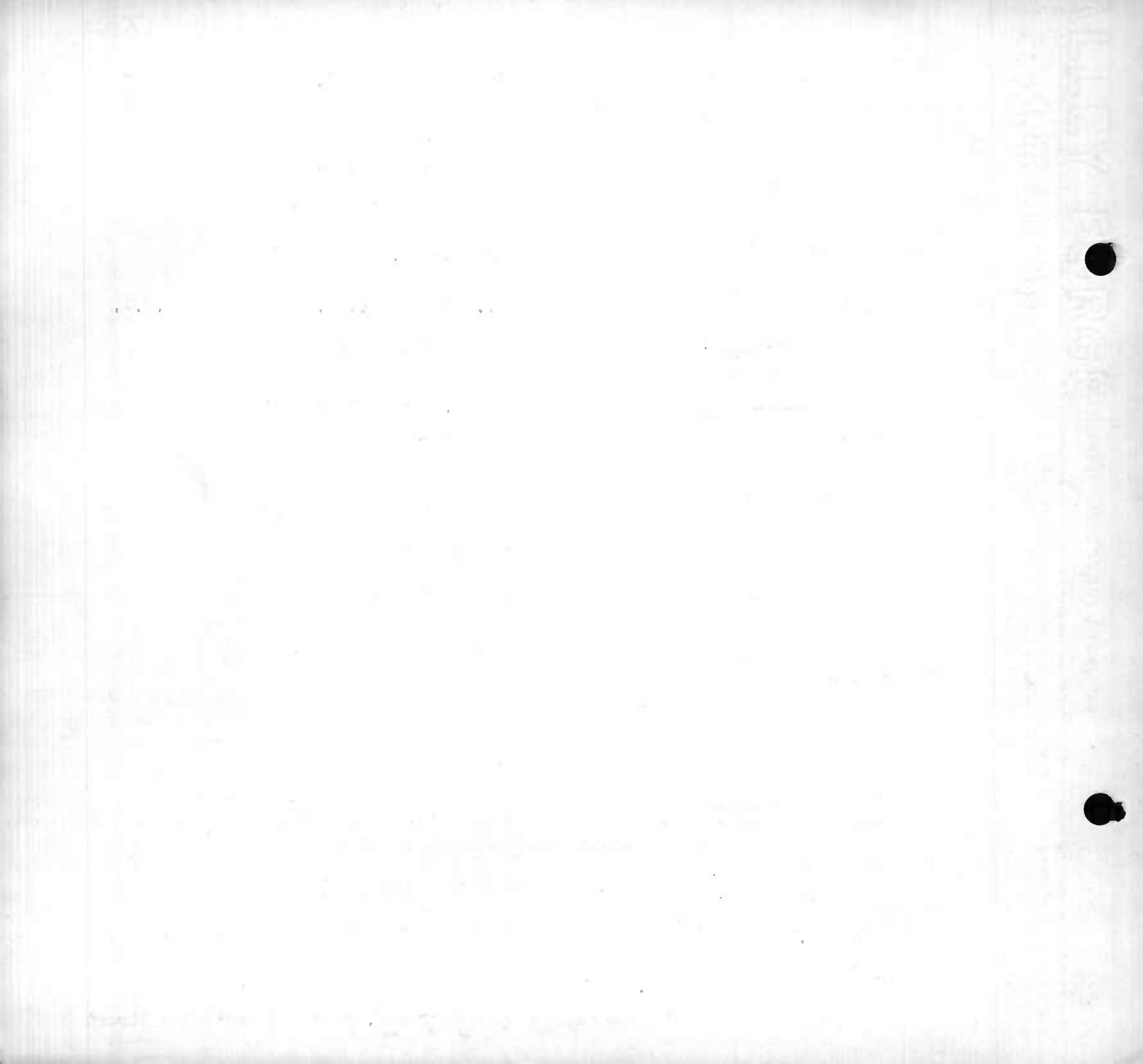
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5730 | |
|---|---|---|--|---|---|
| BIRTH NO. 69 5730 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Alexander Malinowski | | 2. DATE AND HOUR OF DEATH
June 3, 1969 1:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
3806 Hudson Street
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 At Home | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 26-09
C. CITY OR TOWN Baltimore 21224 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3806 Hudson Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 5, 1915 | 9. AGE (In years last birthday)
54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Burner | | 10B. KIND OF BUSINESS OR INDUSTRY
Bethlehem Steel Corp., | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
Anton Malinowski | | 14. MOTHER'S MAIDEN NAME
Boguslawka Amelia Szupstarski | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-07-2697 | | 17. INFORMANT ADDRESS
Mrs. Anna Malinowski 3806 Hudson Street | |
| 18. 148.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Carcinoma, hypopharynx with Metastasis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
with metastasis | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
II | | | | | |
| 19A. DATE OF OPERATION
10/23/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
see 18A | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) XXXXXX attended the deceased from 9/15/67 19 2/12/69 19 2/12 19 69 and that in (my) sex opinion death occurred on the date and hour and from the causes stated above. (I) XXXXXX (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Alvin D. Rudo M.D. | | 23B. DATE SIGNED
6/5/69 | | 23C. PHYSICIAN'S NAME (Type)
Alvin D. Rudo | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/6/69 | | 24C. NAME OF CEMETERY or CREMATORY
St. Stanislaus Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | | |
| 25B. NAME OF REGISTRAR
George A. Weber, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
George A. Weber 705 South Ann Street | | | |

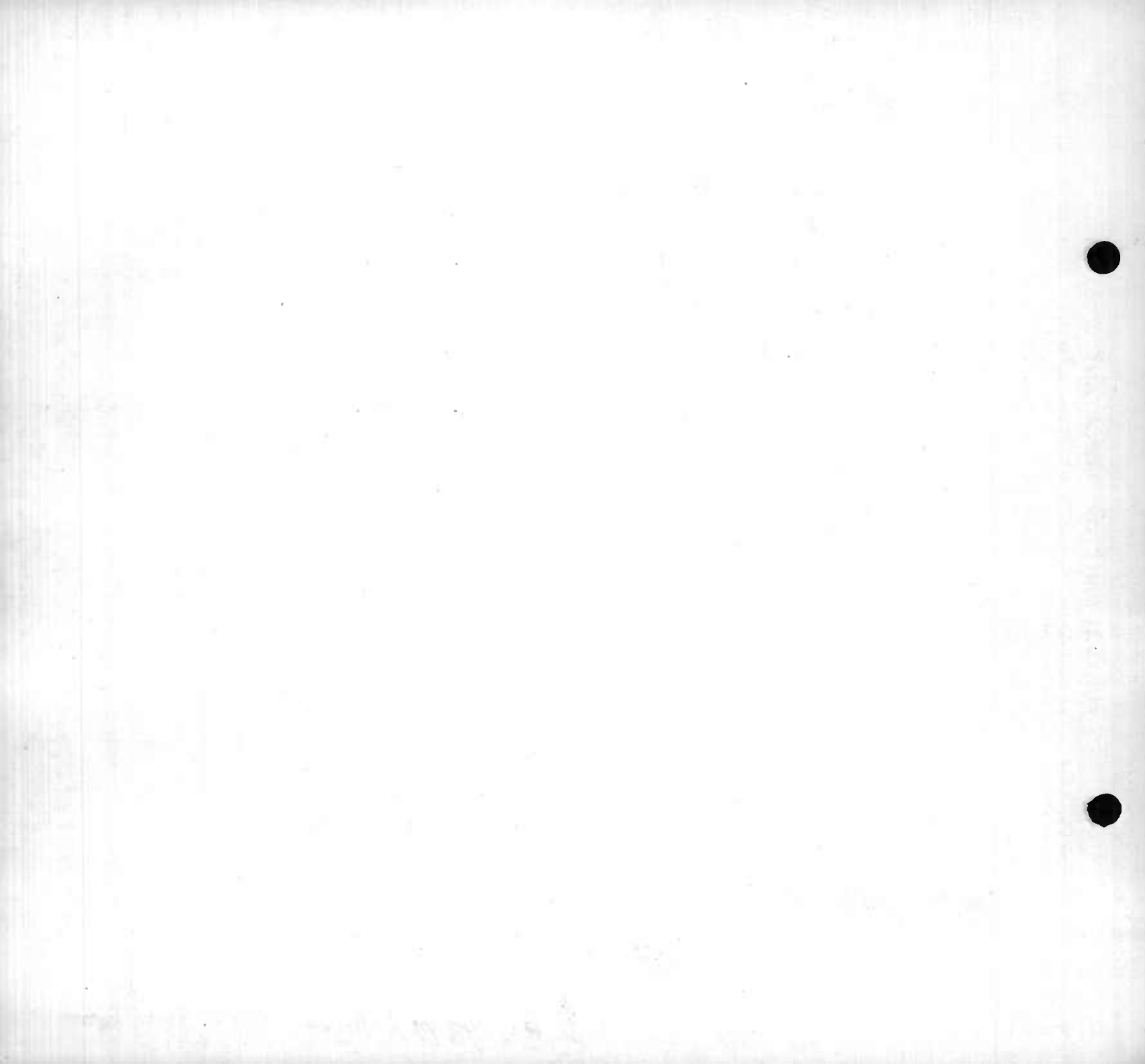


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5731 |
|--|----------------------------------|--|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 69 5731 CERTIFICATE OF DEATH </div> | | | | |
| 1. NAME OF DECEASED
(Type or Print) Belle L. Greene | | | 2. DATE AND HOUR OF DEATH
May 31, 1969 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
5115 Herring Run Drive | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 27-33 | |
| | | | C. CITY OR TOWN
Baltimore, | |
| | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | E. STREET AND NUMBER
5115 Herring Run Drive | |
| 5. SEX
Female | 6. RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 16, 1890 | 9. AGE (In years last birthday)
79 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
School Teacher | | | 11. BIRTHPLACE (State or foreign country)
Port Gibson, Miss. | |
| 13. FATHER'S NAME
John W. Johnson | | | 14. MOTHER'S MAIDEN NAME
Florence Blackburn | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | |
| | | | 17. INFORMANT
Mrs. Amber G. Taylor 5115 Herring Run Drive | |
| | | | ADDRESS | |
| 18. CAUSE OF DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
440.9 I
Pneumonia | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerosis
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from August 1960 to May 31, 1969, that (I) (we) last saw the deceased alive on May 30, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Jesse T. Holmes M.D. | | | 23B. DATE SIGNED
6/3/69 | |
| 23C. PHYSICIAN'S NAME (Type)
Jesse T. Holmes M.D. | | | 23D. ADDRESS
508 E NORTH AVE. BALTO. MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
June 6, 1969 | | 24C. NAME OF CEMETERY or CREMATORY
Scott Cemetery |
| | | 24D. LOCATION (City, town, or county) (State)
Port Gibson Miss. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Joseph H. Rouse |
| | | ADDRESS
2222 W. North Avenue | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | REG. NO. | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| Abraham H. Bennett | | 6-2-69 12:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Md. B. COUNTY 17-01 | |
| 38 University of Md Hospital | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX M 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-2-95 9. AGE (In years last birthday) 73 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore | | 10B. KIND OF BUSINESS OR INDUSTRY Shipping | |
| 11. BIRTHPLACE (State or foreign country) Barbours S.C. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME Thomas Bennett | | 14. MOTHER'S MAIDEN NAME Elizabeth ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes KWI | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Hawthorne Bennett | | ADDRESS 620 1/2 Sarge St 21201 | |
| 18. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary occlusion | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (B) DUE TO, OR AS A CONSEQUENCE OF: A S H D | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: Chronic alcoholism, cirrhosis | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (t) (this hospital) attended the deceased from June 1 1969 to June 2 1969 that (t) (we) last saw the deceased alive on June 2 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (t) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Paul R. Spilshorn M.D. | | 23B. DATE SIGNED 6-2-69 | |
| 23C. PHYSICIAN'S NAME (Type) Paul R. Spilshorn MD | | 23D. ADDRESS University Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 6/5/69 | |
| 24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 5 1969 | | 25B. NAME OF REGISTRAR Robert E. Taylor, MD | |
| 25C. FUNERAL DIRECTOR Williams General Home | | ADDRESS 3911 Schenck St | |

Thomas
Yc

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 5733 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | | | REG. NO. 69 5733 | | | |
|--|--|---------------------|--|---|--|--------------------------------------|--|---|--|-----------------------------|--|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) BUTLER, LOUISE. | | | | | | | | 2. DATE AND HOUR OF DEATH
6-2-69 8:40 P. M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 4-02 | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNIVERSITY OF MARYLAND HOSPITAL | | | | | | | | C. CITY OR TOWN
CITY | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER
38 22 S. GREENE ST. | | | | | | | | | | | | | | | |
| 5. SEX
F | | 6. RACE
N | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-17-1920 | | 9. AGE (In years last birthday) 48 | | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
DOMESTIC | | | | 10B. KIND OF BUSINESS OR INDUSTRY
- | | | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
JOSEPH BUTLER | | | | | | | | 14. MOTHER'S MAIDEN NAME
BESSIE HALL | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
- | | | | 17. INFORMANT
Constance Palmer | | | | ADDRESS
1058 Arundel Ave | | | |
| 18. 180X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) IMMEDIATE CAUSE SEPTICEMIA - RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF:
(B) SQUAMOUS CELL CARCINOMA OF THE CERVIX, STAGE THREE
DUE TO, OR AS A CONSEQUENCE OF:
(C) ? | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
? | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
RENAL FAILURE, ANEMIA 2+ | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
- | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | | 20A. AUTOPSY? (Yes or No)
NO | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
- | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.)
- | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR?
- | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-29 1969 to 6-2 1969 that (I) (we) last saw the deceased alive on 6-2-69 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
Julio E. Alarcon | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
6-2-69 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Julio E. Alarcon | | | | | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
6/6/1969 | | | | 24C. NAME OF CEMETERY OR CREMATORY
St. Albans Cem. | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | | | 25B. NAME OF REGISTRAR
Robert E. Taylor M.D. | | | | 25C. FUNERAL DIRECTOR
Williams Funeral Home | | | | ADDRESS
319 N. Broadway St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

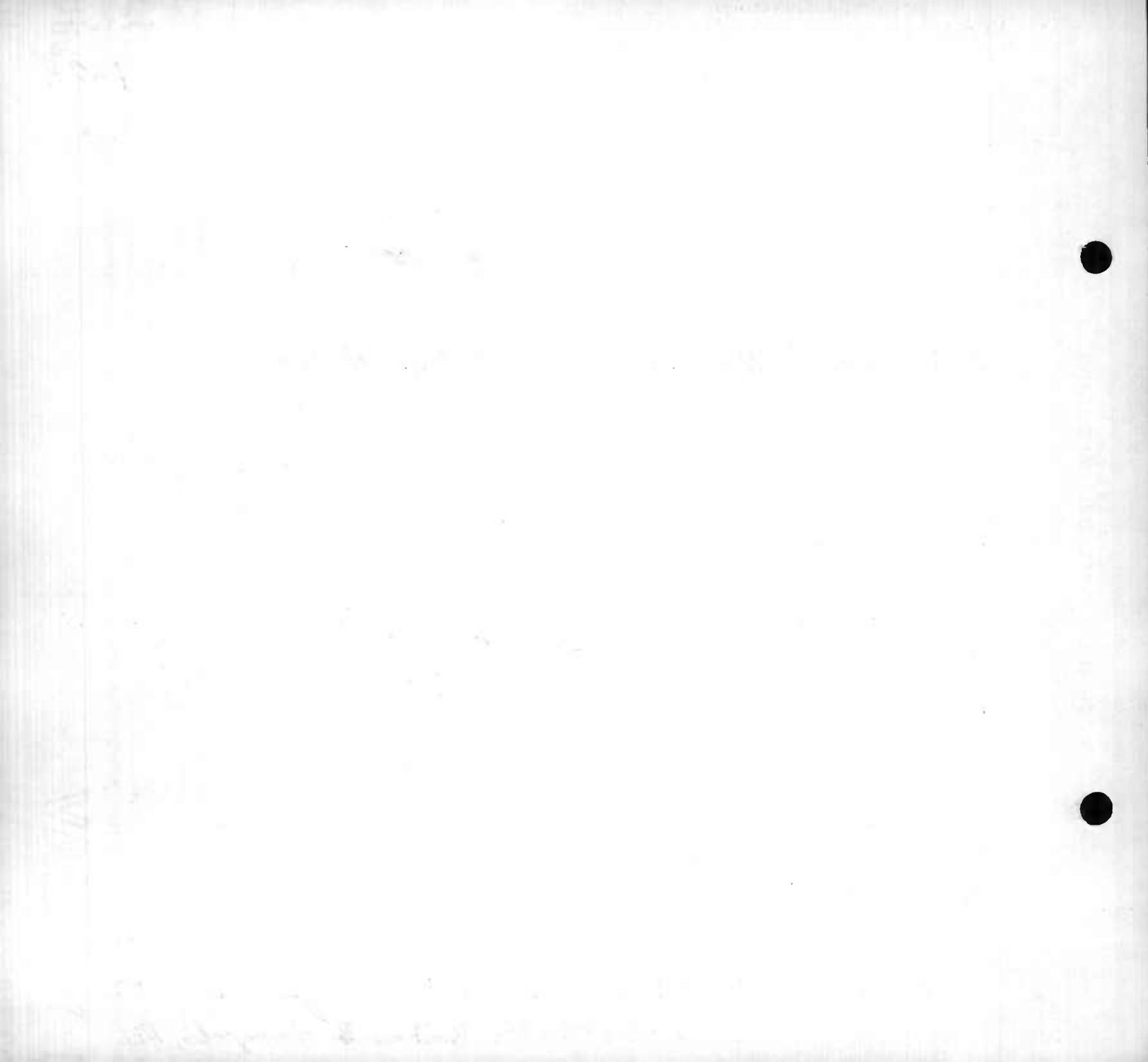
| BIRTH NO. 69 5734 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5734 | | | |
|---|--|------------------|--|--|--|---------------------------------|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) MARY E. SHIPLEY | | | | 2. DATE AND HOUR OF DEATH
6/4/69 11:30 P.M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
MARYLAND GENERAL HOSPITAL 48 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY BALT. C. CITY OR TOWN CITY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | E. STREET AND NUMBER MARYLANDER APTS | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/18/84 | | 9. AGE (In years last birthday) 84 | | 10. If Under 1 Yr. Months: — Days: — Hours: — Min. — | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | | | 10B. KIND OF BUSINESS OR INDUSTRY — | | | | 11. BIRTHPLACE (State or foreign country) BALTIMORE Md | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JAMES R. SHIPLEY | | | | 14. MOTHER'S MAIDEN NAME ELLA THOMPSON | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 12 05 9398 | | 17. INFORMANT NIECE | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
4/2/4 I | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMBOLISM
(B) ASCVD
(C) FRACTURE (RT) HIP | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hrs. | | | |
| 19. DATE OF OPERATION April 29, 69 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fr (RT) hip | | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/3/69 19 to 6/4/69 19 that (I) (we) lost saw the deceased alive on 6/4/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE J. P. Baker MD | | | | 23B. DATE SIGNED 6/4/69 | | | | 23C. PHYSICIAN'S NAME (Type) JOE P. BAKER | | | |
| 23D. ADDRESS Maryland General Hospital | | | | 23E. NAME OF REGISTRAR J. P. Baker, MD | | | | 23F. FUNERAL DIRECTOR J. W. Jenkins & Sons Co | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 6-7-1969 | | | | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge | | | |
| 24D. LOCATION (City, town, or county) Pikesville, Balto. Co., Md. | | | | 24E. DATE REC'D BY HEALTH DEPT. JUN 5 1969 | | | | 24F. ADDRESS 4905 York Road Balto., Md. 21212 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. |
|--|--|---|--|--|
| 69 5735 | | CERTIFICATE OF DEATH | | 69 5735 |
| BIRTH NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| WILLIAM HARRID | | 6-2-69 1340 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | |
| SINAI Hospital | | Md A.A.P. 52-00 | | |
| 42 | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | BALTO | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER | | F. STREET AND NUMBER | | |
| | | Annapolis Md. | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) |
| M | N | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 6/9/1886 | 82 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| | | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| Dennis B. Harrid | | Eliza A. Harrid | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| | | | | |
| 18. 412.4 + 250.9 | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | hours |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | Cerebrovascular Territory | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | yes |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | ASCVD | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | Diabetes, Epilepsy | | several years |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | yes | not available yet | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? | | |
| | | (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | |
| (Month) (Day) (Year) (Hour) | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1968 to 6-2-69 1969 that (I) (we) last saw the deceased alive on May 29 1969 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | |
| Joseph Shear MD | | 6-4-69 | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | |
| Joseph Shear MD | | Agnes Center SINAI Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY |
| Burial | | 6-7-1969 | | Hope Memorial |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS |
| JUN 5 1969 | | Robert E. Taylor, M.D. | | Wm. Robert E. Annapolis, Md |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

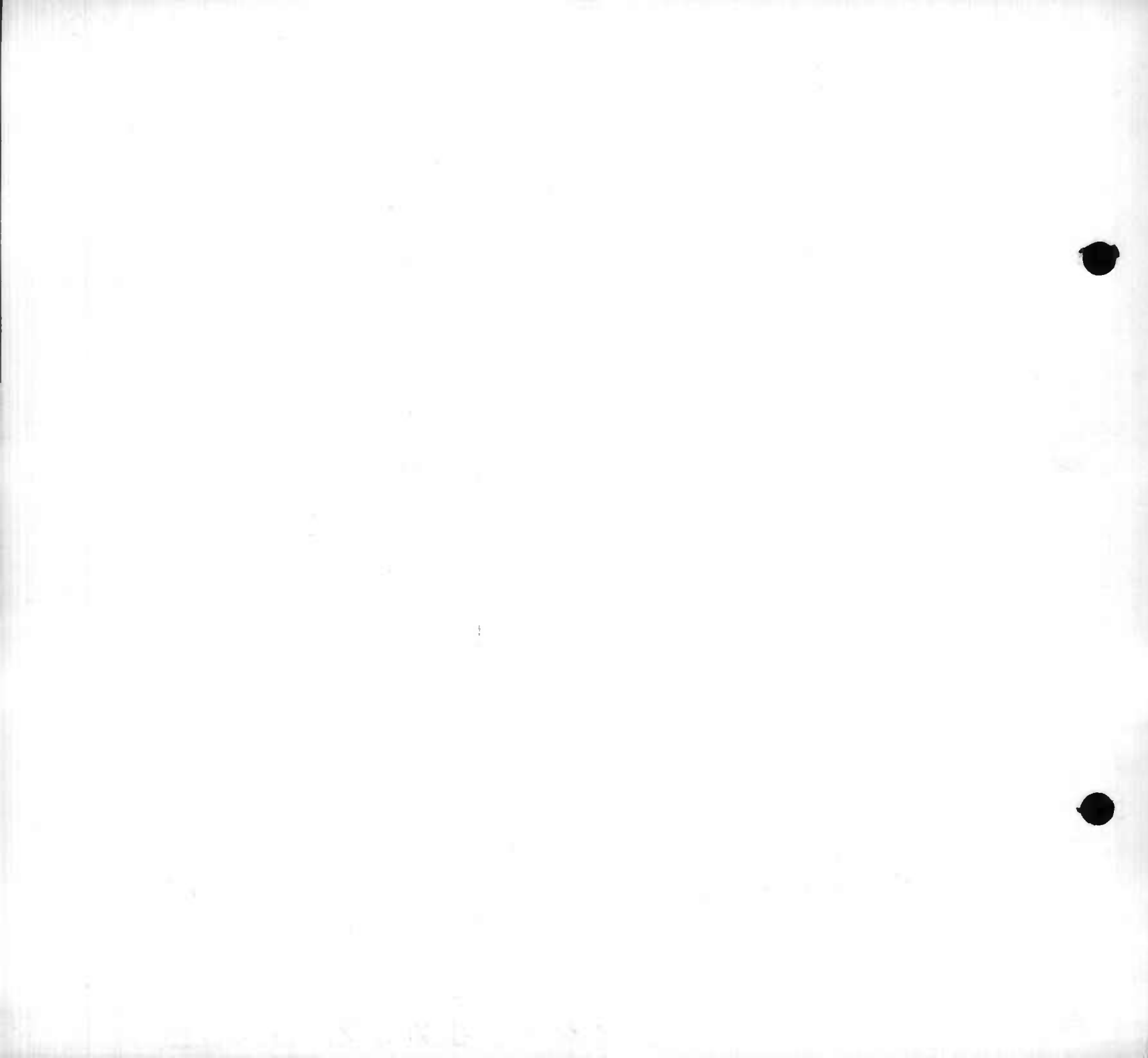
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5736 | |
|---|---|---|--|--|--|
| BIRTH NO. 69 5736 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Lolita Mitchell | | 2. DATE AND HOUR OF DEATH
JUNE 2, 1969 10:00 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Sinai Hospital of Baltimore | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY 8-02 | | | |
| | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
1723 Montford | | | |
| 5. SEX
F | 6. RACE
N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4-15-1925 | 9. AGE (in years lost birthday)
44 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | 13. FATHER'S NAME
Sylvester Stanton | | 14. MOTHER'S MAIDEN NAME
Alice Matthews | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
218-18-6368 | | 17. INFORMANT
Mr. Irvin Mitchell | |
| | | | | ADDRESS
Same | |
| 18. 180X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Uremia
DUE TO, OR AS A CONSEQUENCE OF:

(B) Recto-urinary fistula 2° Radiation therapy
DUE TO, OR AS A CONSEQUENCE OF:
(C) CA of Cervix | |
| | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 yrs | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (if) (this hospital) attended the deceased from 5/15 19 69 to 6/2 19 69 that (if) (we) lost saw the deceased alive on 6/2 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
M. Florenschein | | | | 23B. DATE SIGNED
6/2/69 | |
| 23C. PHYSICIAN'S NAME (Type)

DEGREE | | | | 23D. ADDRESS
Sinai Hospital
DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-6-69 | | 24C. NAME OF CEMETERY or CREMATORY
Carver Mem. PK. | |
| 24D. LOCATION
Laurel, Md | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR
MORTIMER BYETT F.H. | | | |
| | | ADDRESS
1701 Laurens St | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
BRUCE JOHNSON | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
6 3 69 7:30 a. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
38 University Hospital | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 3, 1969 7:30a. M. | |
| 6. SEX
Male | | 7. RACE
Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
11-14-1950 | | 10. AGE (In years lost birthday)
18 | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | 14B. KIND OF BUSINESS OR INDUSTRY
Job Corp. | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
Mrs. Amy Johnson | | ADDRESS
2936 Edmondson Avenue | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
E9661X | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Massive hemorrhage at rupture of
(B) DUE TO, OR AS A CONSEQUENCE OF:
false aneurysm developing at
(C) site of stab wound. | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
<input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
00-00 | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)
8 ? 68 ? | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Subject stabbed | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edw F Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED June 4, 1969 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-7-69 | |
| 24C. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | | ADDRESS
1701 Laurens St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| BIRTH NO. 69 5738 | | | | | REG. NO. 69 5738 | | | | |
| 1. NAME OF DECEASED
(Type or Print) JAMES WOODS | | | | | 2. DATE AND HOUR OF DEATH
5-31-69 18:15 A. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | | | | A. STATE
MARYLAND | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
BALTIMORE, MD 21205 | | | | | B. COUNTY
7-04 | | | | |
| 5. SEX
MALE | | | | | 6. RACE
NEGRO | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH
4-21-19 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Labor | | | | | 11. BIRTHPLACE (State or foreign country)
Woodward SC | | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | |
| 13. FATHER'S NAME
JIM WOODS | | | | | 14. MOTHER'S MAIDEN NAME
MARY FOSTER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
251-12-9013 | | | | |
| 17. INFORMANT
Louise Woods | | | | | ADDRESS | | | | |
| 18. CAUSE OF DEATH
433.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Intra cerebral Hemorrhage
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks | | | | |
| 19A. DATE OF OPERATION
0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No)
NO | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | | | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/13 19 69 to 5/31 19 69 that (I) (we) last saw the deceased alive on 5/30/69 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | 23A. SIGNATURE
David A. Bass | | | | |
| 23B. PHYSICIAN'S NAME (Type)
DAVID A. BASS | | | | | 23C. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | | 24B. DATE
6-3-69 | | | | |
| 24C. NAME of CEMETERY or CREMATORY
MT. AUBURN | | | | | 24D. LOCATION (City, town, or county) (State)
BALTO MD. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | | | | 25B. NAME OF REGISTRAR
Wm. E. Taylor, M.D. | | | | |
| 25C. FUNERAL DIRECTOR
E. P. Wilson | | | | | ADDRESS
1000 BRANTLEY AVE | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5739
REG. NO.

BIRTH NO.

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print) REV. THOMAS HARRIS | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 3, 1969 8:33 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 1747 E. Lafayette Avenue | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 3, 1969 8:33 P. M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 8-06 | | | |
| 6. SEX
Male | 7. RACE
Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
10/2-1894 | | 10. AGE (In years last birthday) 74
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Norfolk Va | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Minister | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME
Laura Harris | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
YES | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
Minnie E. Harris Aunt | | ADDRESS | |
| 19. 153.8
CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of colon with perforation and
(A) IMMEDIATE CAUSE
due to a generalized peritonitis
generalized peritonitis
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 6/4/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-9-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Balto National Cmt | | 24D. LOCATION (City, town, or county) (State)
Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
6/5/69 | | 25B. NAME OF REGISTRAR
Robert E. Barber, M.D. | |
| 25C. FUNERAL DIRECTOR
George Wilson 1000 Cranberry Ave | | ADDRESS | |

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W.F. ALLEN

W.F. ALLEN
PAPER

1
P-650

69 5740 BALTIMORE CITY HEALTH DEPARTMENT

69 5740

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LOWIS PARRON

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

6

4

69

9:00 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 523 N. Stricker St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June

4

1969

9:00 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

16-02

6. SEX

Male

7. RACE

Colored

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)If Under 1 Yr. if Under 24 Hrs.
Months Days Hours Min.

Jan 1-1909

60

E. STREET AND NUMBER

523 N. Stricker St.

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George James

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Annie Parron

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

No

17. SOCIAL
SECURITY NO.

217-03-8734

18. INFORMANT

Mary Lucas 1810 W. Lexington St

ADDRESS

19. 412.4 1 250.9
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

complicated by diabetes mellitus

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RONALD N. KORNBLUM, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 4, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUN 5 1969

Robert E. Fisher, M.D.

Elroy Wilson 1000 Brantly St

ALL

Order 6-11

Highly confidential

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5741

BIRTH NO.

| | | | |
|--|---|--|--|
| 1. NAME OF DECEASED
(Type or Print) (HASKINS) DORTHY HUSKIN | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> May 29, 1969 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
00 2701 West Fairmount Avenue | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 29, 1969 8:05 A.M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 20-02 | | | |
| 6. SEX
Female | 7. RACE
Negro | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN
Baltimore
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH
53 | 10. AGE (In years last birthday)
53 | E. STREET AND NUMBER
2701 West Fairmount Avenue | |
| 11. BIRTHPLACE (State or foreign country)
Yorktown Va. | 12. CITIZEN OF WHAT COUNTRY?
USA | 13. FATHER'S NAME
SIMON BROOKS | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO. | 18. INFORMANT
IDA SIMPSON ADDRESS
Sis. INCLAD 2513 LINDEN AVE |
| 19. 188X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Carcinoma of urinary bladder | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
(C) _____ | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
(Partial) Yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
(Partial) | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23.
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Springate M.D.
EXAMINER'S NAME (Type) Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED May 29, 1969 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 24B. DATE
6-2-69 | 24C. NAME of CEMETERY or CREMATORY
BALTO NAT'L CEM | 24D. LOCATION (City, town, or county) (State)
BALTO MD |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | 25C. FUNERAL DIRECTOR
E. D. NELSON ADDRESS
1000 BRANTLEY | |

THE NATIONAL ARCHIVES

RECORDS OF THE DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

ADJUTANT GENERAL'S OFFICE

RECEIVED

OFFICE OF THE ADJUTANT GENERAL

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

JAMES

JOHNSON

2. DATE
OF DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

June

2,

1969

12:08P

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

5-01

6. SEX

male

7. RACE

negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1209 Nolan Court, Apt. 2A

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Annie Johnson Same

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes (Partial)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ P. Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/3/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

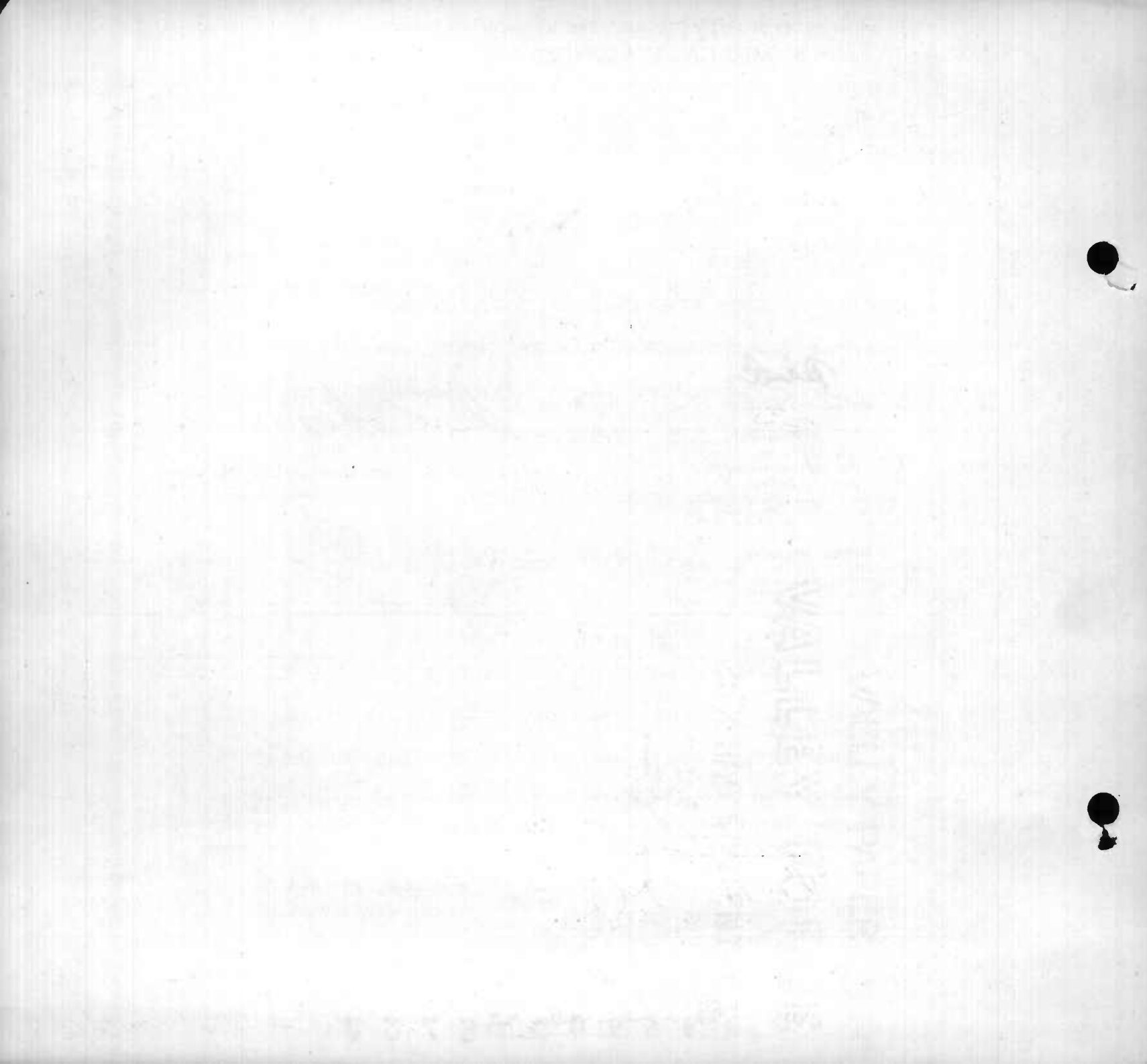
24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

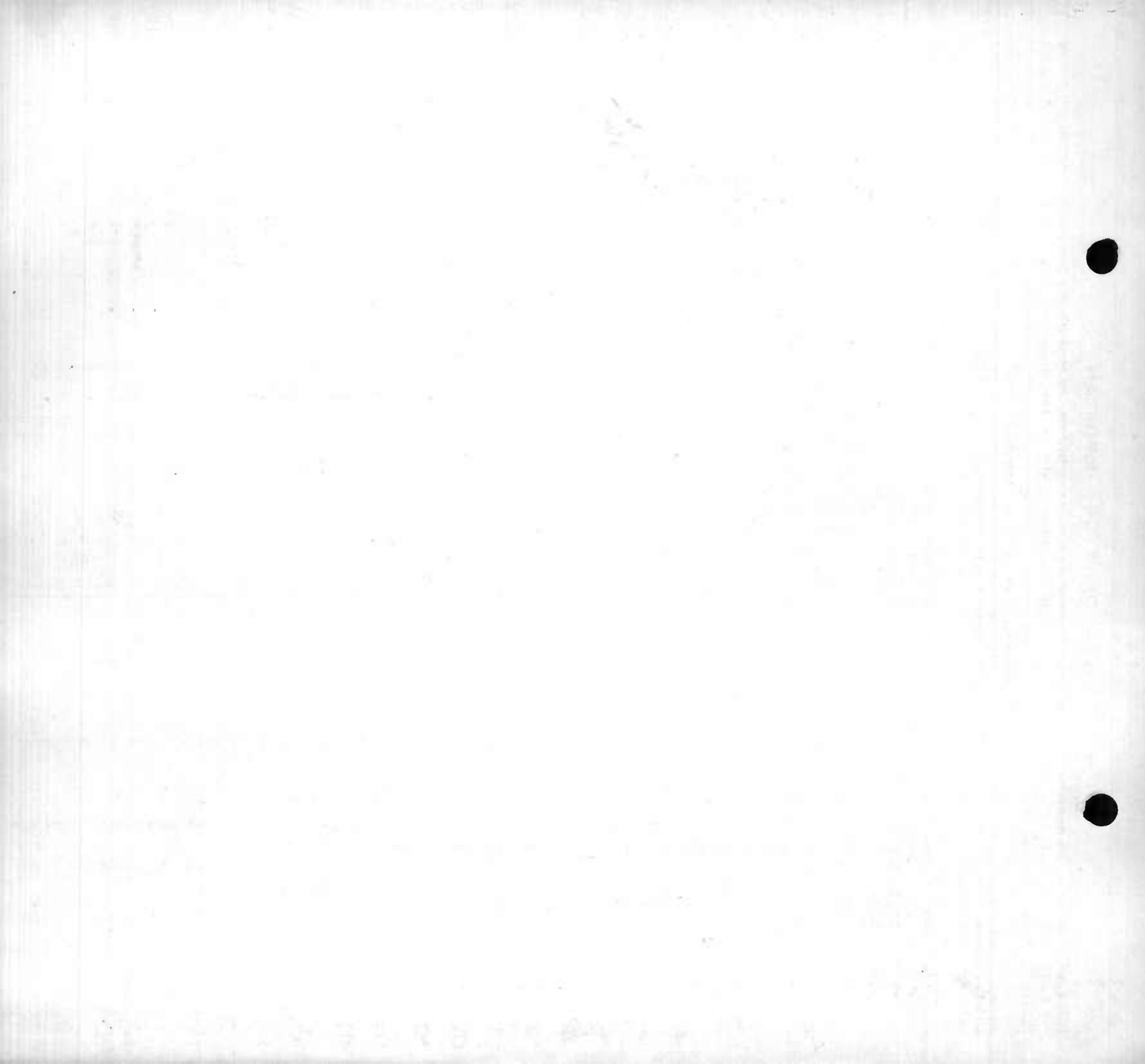
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5743 | |
|---|------------------|---|------------------------------------|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Hazel Harris</u> | | 2. DATE AND HOUR OF DEATH
<u>5-29-69</u> <u>11:30</u> <u>P</u> <u>M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>Balt</u> | | C. CITY OR TOWN <u>Balt</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>University of Md Hospital</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
<u>3469 Faint Ct #26</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>5-10-02</u> | 9. AGE (In years last birthday)
<u>67</u> | 10. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Richmond Va</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lanane Woodson</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)
<u>No</u> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Douglas Williams</u> | | ADDRESS | |
| 18. <u>410.9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>Liver dysfunction</u> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>Myocardial infarction</u>
(B) <u>ASHD, COPD</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
<u>3:00 PM</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <u>3-3</u> 19 <u>69</u> to <u>5-29</u> 19 <u>69</u> that it (we) last saw the deceased alive on <u>5-29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. It (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Paul R. Spilsbury M</u> | | 23B. DATE SIGNED
<u>5-29-69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Paul R. Spilsbury M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6-4-69</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>McCahey Cmt</u> | |
| 24D. LOCATION
<u>A.A. County Md</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 5 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, M.D.</u> | |
| 25C. FUNERAL DIRECTOR
<u>Charles William Wood</u> | | 25D. ADDRESS
<u>University Hospital</u> | | 25E. ADDRESS
<u>1000 Brewster St</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5744 | |
|--|--|---------|--|----------------------|--|
| BIRTH NO. 5-320 | | 69 5744 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) SHOATS, ROBERT | | | 2. DATE AND HOUR OF DEATH
5/26/69 1140 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
BALTIMORE CITY HOSPITALS
31BA 4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX
MALE | | | 6. RACE
NEGRO | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
SOUTH CAROLINA |
| 13. FATHER'S NAME
WILL SHOATES | | | 14. MOTHER'S MAIDEN NAME
MAE CROSBY | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
BCH RECORDS-4940 EASTERN AVE. BALTO, MD. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
153,314,011,9 | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
CARDIO-RESPIRATORY ARREST | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 min |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,
(B) ADENOCARCINOMA OF LUNG WITH METASTASES
(C) Tumor | | | | | 3 yrs
10 yrs |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
CHRONIC ALCOHOLISM | | | | | 20 YRS |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 3/7 1969 to 5/26 1969, that (I) (we) last saw the deceased alive on 5/26 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
V. Valdmantis, MD | | | 23B. DATE SIGNED
5/26/69 | | 23C. PHYSICIAN'S NAME (Type)
V. VALDMANTIS, MD. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
REMOVAL | | | 24B. DATE
5/29/69 | | 24C. NAME OF CEMETERY OR CREMATORY
GASTONIA CEM |
| 24D. LOCATION (City, town, or county)
GASTONIA N.C. | | | 24E. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 24F. NAME OF REGISTRAR
Robert E. Jackson, MD. |
| 24G. FUNERAL DIRECTOR
E. G. WILSON | | | 24H. ADDRESS
1000 BRANTLEY AVE | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5745 | |
|--|------------------|---|-----------------------------|---|---|
| BIRTH NO. 69 5745 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) JOHNSON, ADDIE Cook | | 2. DATE AND HOUR OF DEATH
May 30 1969 2:45 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore CO. 53-00 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
33 JOHNS HOPKINS HOSPITAL
601 N. BROADWAY
BALTIMORE, MARYLAND 21205 | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER
1400 RUSTIC AVE. | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/20/96 | 9. AGE (in years last birthday)
73 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Balt Md | |
| 13. FATHER'S NAME
JOHN COOK | | 14. MOTHER'S MAIDEN NAME
REBECCA COOPER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Of yes, give war or dates of service
No | | 16. SOCIAL SECURITY NO.
214-30-0140 | | 17. INFORMANT
Vernon Cook Senior | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
CUA | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF:
HAGCVD | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from May 30 19 69 to May 30 19 69, that (1) (we) last saw the deceased alive on May 30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Matthew Pollock MD | | | | 23B. DATE SIGNED
May 30 1969 | |
| 23C. PHYSICIAN'S NAME (Type)
MATTHEW POLLOCK MD | | | | 23D. ADDRESS
JOHNS HOPKINS HOSP | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-4-69 | | 24C. NAME OF CEMETERY OR CREMATORY
Balt Mt Cat | |
| 24D. LOCATION (City, town, or county) (State)
Balt Md | | 25A. DATE REC'D BY HEALTH DEPT
JUN 5 1969 | | | |
| 25B. NAME OF REGISTRAR
J. E. G. R. D. | | 25C. FUNERAL DIRECTOR
George Wilson 1000 Brantly St | | | |



E-420

69 5746 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5746

BIRTH NO.

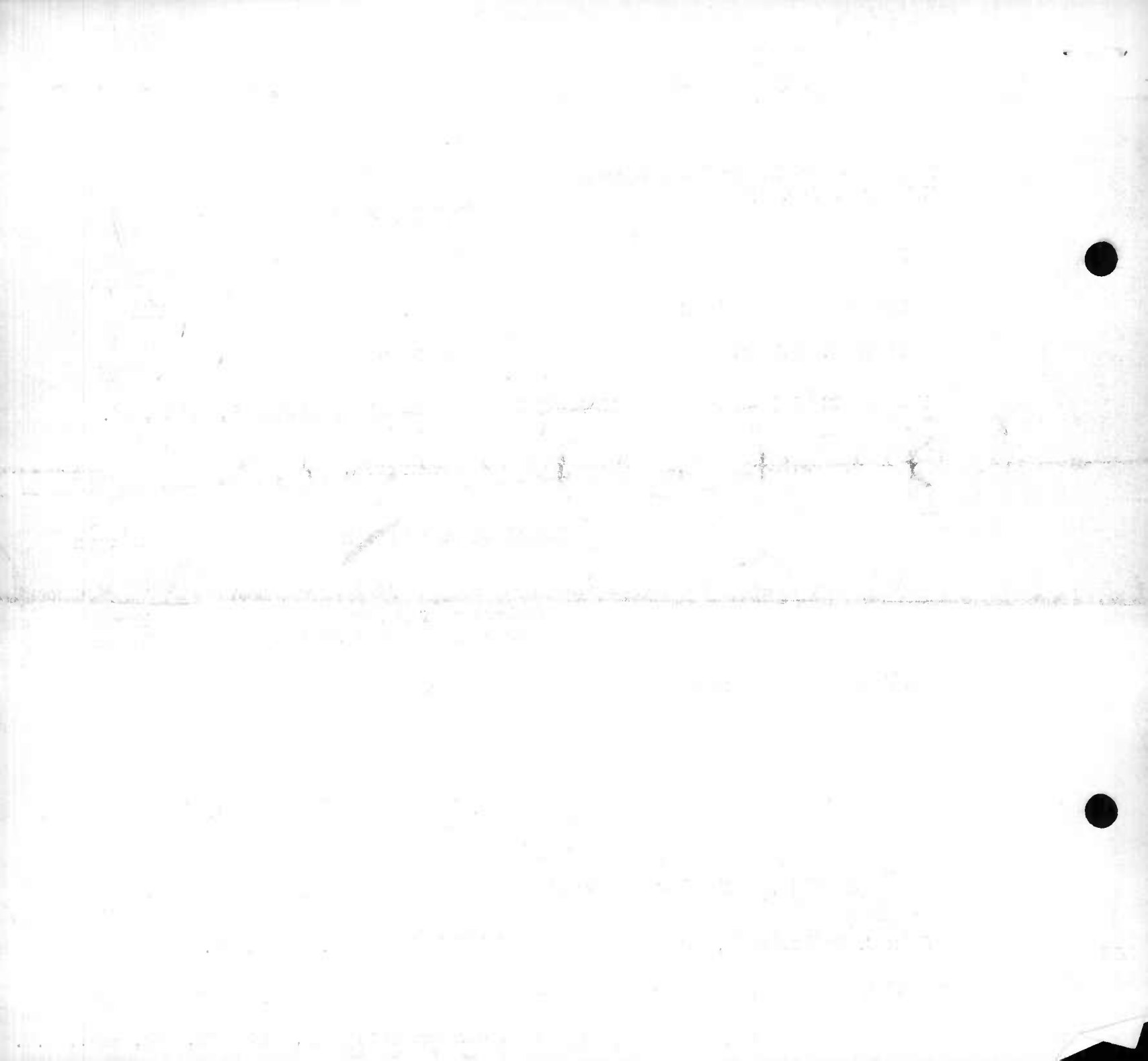
REG. NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
LONNIE BONNIE ELLIS | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year Hour
Estimated <input checked="" type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Lutheran Hospital (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 26, 1969 UNK | |
| 6. SEX
male | | 7. RACE
negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
4-4-1916 | | 10. AGE (In years last birthday)
53 | |
| 11. BIRTHPLACE (State or foreign country)
LITTLE WASHINGTON N.C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME
LOUISA TUCKER | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war and dates of service) | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS
D. ANE COVELL 1817 MARYLAND AVE | |
| 19. E 937.1 | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | Anaphylactic Reaction to Penicillin
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
Yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Doctor's office | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
1005 W. Lafayette Avenue | |
| 22D. TIME OF INJURY (Approx.)
5/26/69 UNK | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR?
Reaction to penicillin after injection for cold | | 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED
5/27/69 | | 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | |
| 24B. DATE
31 MAY 69 | | 24C. NAME OF CEMETERY or CREMATORY
BALTO NATL CEM | |
| 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher, MD. | | 25C. FUNERAL DIRECTOR
E.O. Wilson | |
| 25D. ADDRESS
1000 BRANTLEY | | AVG | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

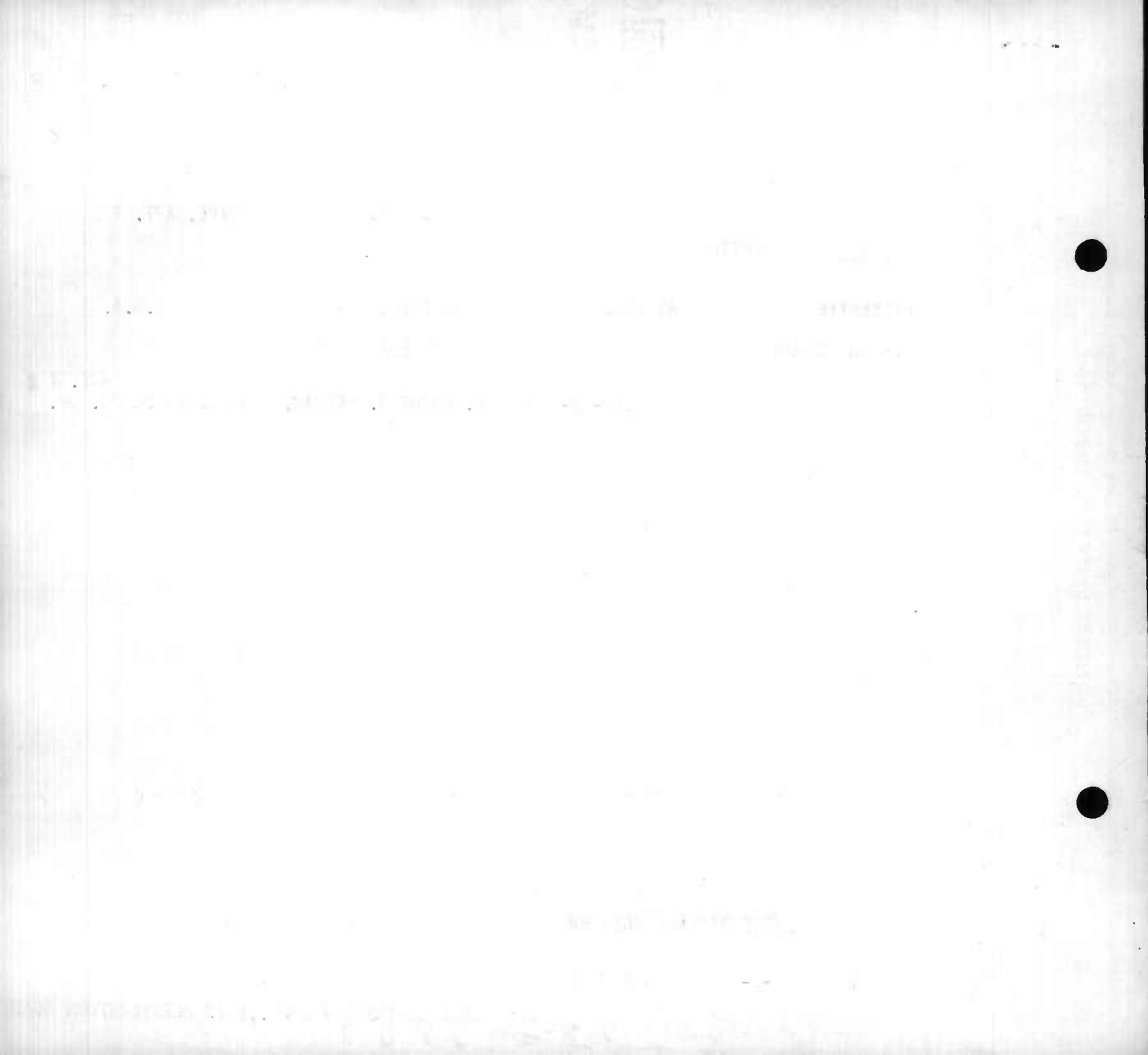
| | | | | | | | |
|--|--------------|---|---|---|--|---|-------------------------------------|
| G-163 | | 69 5747 | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 69 5747 | |
| BIRTH NO. | | | | HARRY | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | HARRY Carlton Gifford | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 2. DATE AND HOUR OF DEATH
May 28, 1969 4 P M. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY
Md. Montgomery 65-00 | | | |
| US Public Health Service Hospital
3100 Wyman Parkway | | | | C. CITY OR TOWN
Silver Spring | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
1237 Noyes Drive | | | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/18/05 | 9. AGE (in years last birthday)
63 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY
USCG | | 11. BIRTHPLACE (State or foreign country)
Mass. | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Harry C. Gifford | | | | 14. MOTHER'S MAIDEN NAME
Florence Cobham | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes CG 1930-1960 | | 16. SOCIAL SECURITY NO.
031-30-2360 | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pneumonia
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Gastroblastoma of brain
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) Emphysema of lungs
Hypertensive heart disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Days
Unknown
Years
Years | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
4/8/69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Brain tumor | | 20A. AUTOPSY? (Yes or No)
yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Mar. 31 19 69 to May 28 19 69 that (I) (we) last saw the deceased alive on May 28 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
John C. Sutherland, MD | | | | 23B. DATE SIGNED
5/29/69 | | 23C. PHYSICIAN'S NAME (Type)
John C. Sutherland, MD | |
| 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
3/31/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 24D. LOCATION (City, town, or county) (State)
Suitland, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Jos Gawler's Sons, 5130 Wis. Ave, Wash., D.C. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5748 |
|--|-------------------------|--|-----------------------------------|--|
| K-620 69 5748 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Krauss, FLORENCE BERMAN | | 2. DATE AND HOUR OF DEATH
6/1/69 6:55 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
Sinai Hospital of Baltimore | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Sinai Hospital of Baltimore | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
6939 MILBROOK PARK DRIVE, APT. T 2 | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/8/08 | 9. AGE (in years last birthday)
60 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
NORFOLK, VIRGINIA |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
JOSEPH BERMAN | | |
| 14. MOTHER'S MAIDEN NAME
FRIEDA ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | |
| 16. SOCIAL SECURITY NO.
215-07-5802 | | 17. INFORMANT ADDRESS
MR. HARRY J. BERMAN, 6936 MILBROOK PK. DR. APT. T 2 | | |
| 18. 433.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Cerebrovascular Hemorrhage
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 hours |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
no | | 20A. AUTOPSY? (Yes or No)
no |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
--- | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
--- |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
--- | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
--- |
| 22. I certify that (I) (this hospital) attended the deceased from 1966 to June 1 19 69 , that (I) (we) last saw the deceased alive on June 1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Herbert Gundersheimer M.D. | | 23B. DATE SIGNED
6-1-69 | | 23C. PHYSICIAN'S NAME (Type)
HERBERT GUNDERSHEIMER |
| 23D. ADDRESS
SINAI HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | |
| 24B. DATE
6-3-69 | | 24C. NAME OF CEMETERY or CREMATORY
BNAI JACOB | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
DAVID BIRENBAUM | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> June 2, 69 8:10 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Sinai Hospital D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 2, 1969 8:10 a.m. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
BALTIMORE | |
| 9. DATE OF BIRTH
SEPT. 21, 1923 | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years last birthday)
45 | | E. STREET AND NUMBER
4031 Cold Spring Lane | |
| 11. BIRTHPLACE (State or foreign country)
POLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ELECTRICAL | | 14B. KIND OF BUSINESS OR INDUSTRY
BUILDING | |
| 15. MOTHER'S MAIDEN NAME
UNKNOWN | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | |
| 17. SOCIAL SECURITY NO.
213-28-0982 | | 18. INFORMANT
MR. ARNOLD BIRENBAUM, 4031 W. COLD SPRING LANE | |
| 19. CAUSE OF DEATH
E812.10
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
CRANIOCEREBRAL INJURIES
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15-10 | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
YES | | 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
Intersection Callow Ave. & Sequoia Ave. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Intersection Callow Ave. & Sequoia Ave. | |
| 22D. TIME OF INJURY (APPROX.)
6 2 69 7:50 a.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR?
Subject driver in auto-ayyo coll. | | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE
Edward F. Wilson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| NAME (Type)
Edward F. Wilson, M.D. | | DATE SIGNED
June 2, 1969 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-3-69 | |
| 24C. NAME of CEMETERY or CREMATORY
RUDOMER VEREIN | | 24D. LOCATION (City, town, or county) (State)
ROSEDALE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
James E. Garber, M.D. | |
| 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS & INC. | | ADDRESS
6070 REISTERSTOWN ROAD #21215 | |

BALTIMORE
KANSAS CITY

SEPT. 11, 1923

POLAND U.S.A. STEPHENSON

ELECTRICAL BUILDING

NO. 212-14-0482 MR. ARTHUR STEPHENSON, 4031 N. COLE STREET, CHICAGO

Handwritten signature

CHICAGO, ILL. 9-1-23

201 BROADWAY, NEW YORK
201 BROADWAY, NEW YORK

FUNERAL DIRECTOR: IMPORTANT

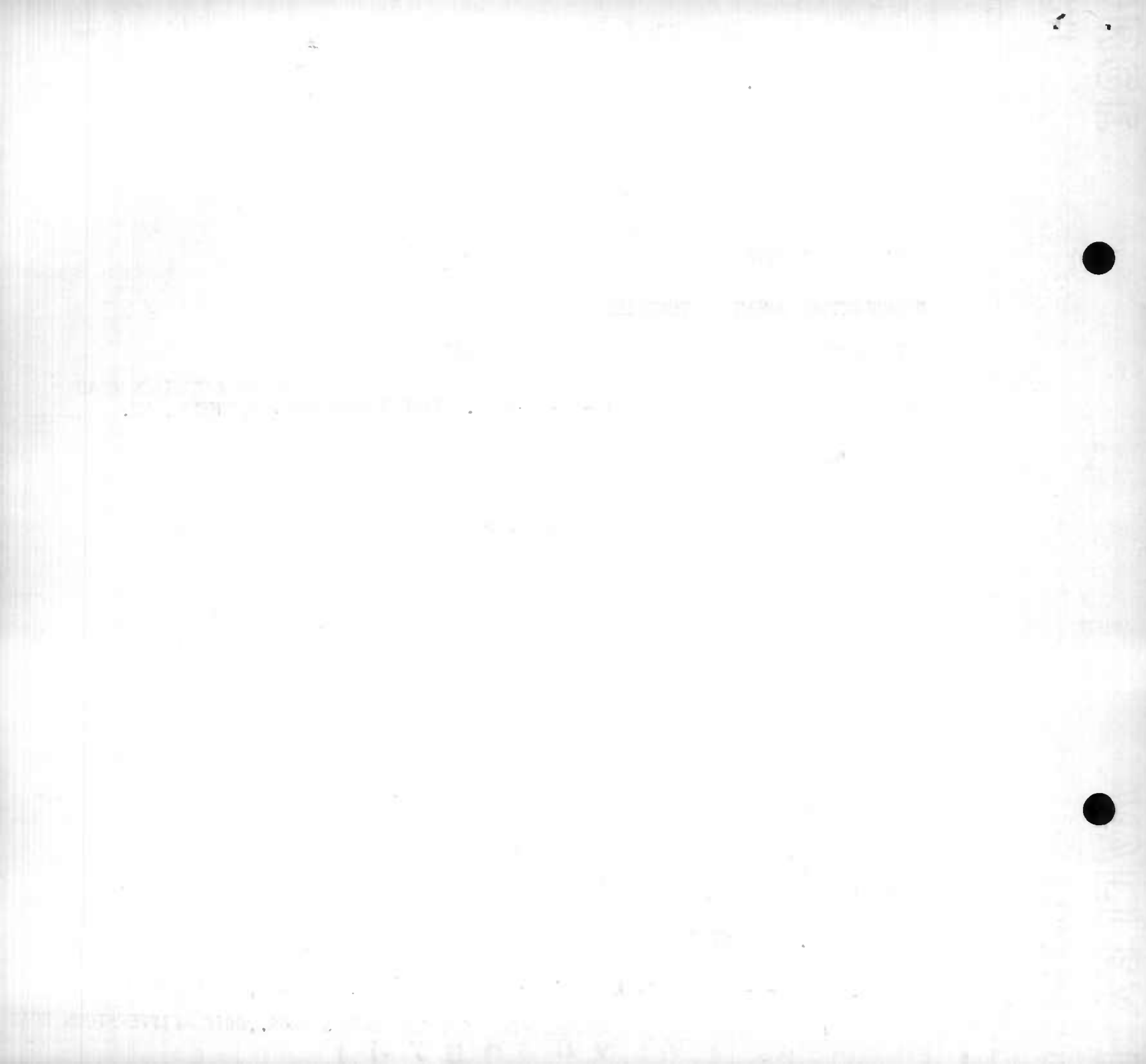
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5750 | |
|---|---|---|---|---|--|
| BIRTH NO. 69 5750 | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) JACOB D. LESSENCO | | | 2. DATE AND HOUR OF DEATH
6/3/69 12:20 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SINAI Hospital of Baltimore | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
5716 RANNY RD | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7/4/1890 | 9. AGE (In years last birthday)
78 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MANUFACTURE AGENT | | 10B. KIND OF BUSINESS OR INDUSTRY
TEXTILES | | 11. BIRTHPLACE (State or foreign country)
Russia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | 13. FATHER'S NAME
DAVID LESSENCO | | |
| 14. MOTHER'S MAIDEN NAME
KATE ? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | |
| 16. SOCIAL SECURITY NO.
216-03-6460 | | | 17. INFORMANT
MR. GILBERT LESSENCO, BETHESDA, MD. | | |
| 18. 4124 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE CVA
DUE TO, OR AS A CONSEQUENCE OF:

(B) ASCVD
DUE TO, OR AS A CONSEQUENCE OF:

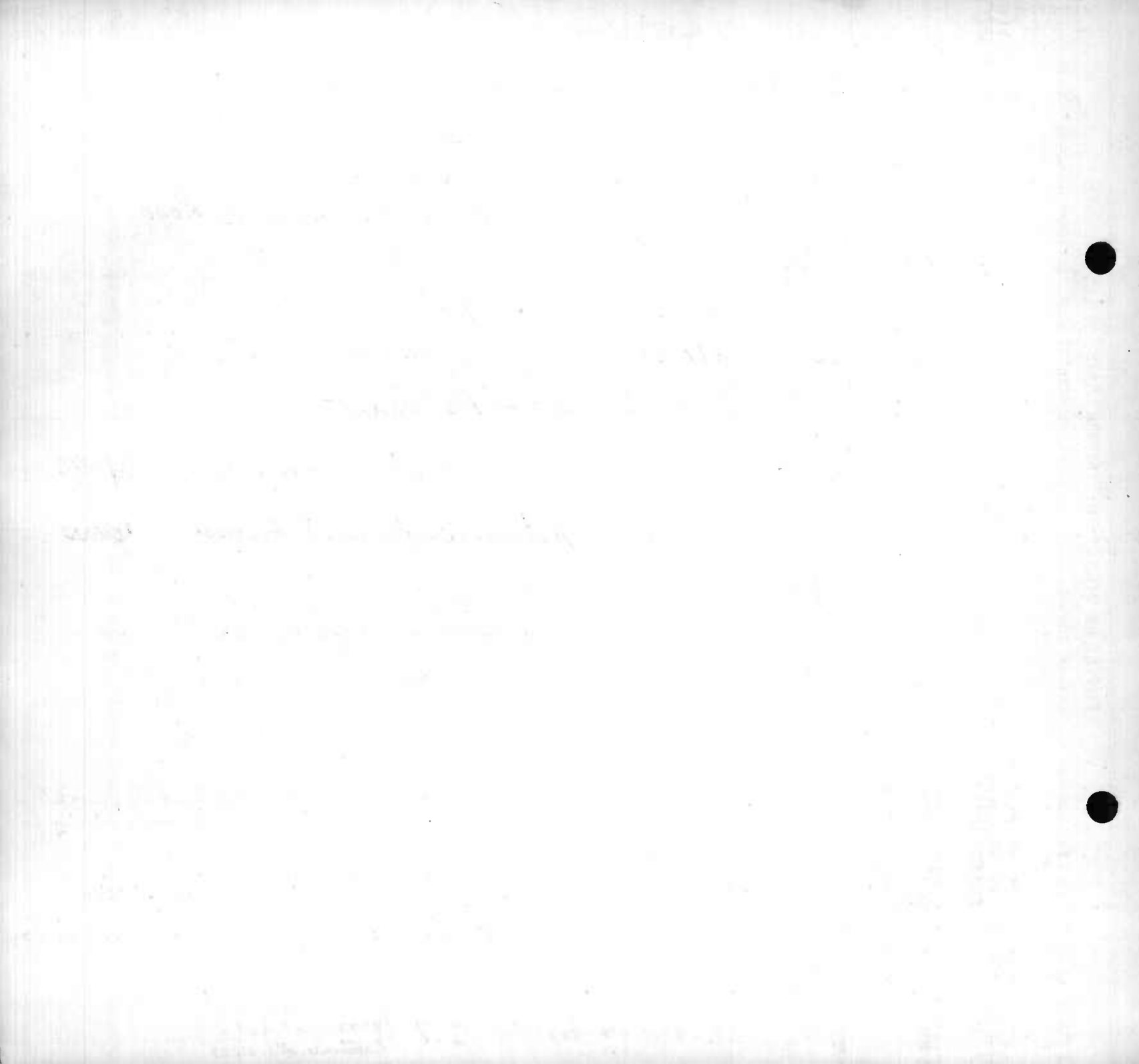
(C) _____ | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
CORONARY INSUFFICIENCY | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5-9 1969 to 6/3 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6/3 1969 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
M. Horenstein M.D. | | | 23B. DATE SIGNED
6/3/69 | | |
| 23C. PHYSICIAN'S NAME (Type)
M. HORENSTEIN | | | 23D. ADDRESS
Sinai Hosp | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-4-69 | | 24C. NAME OF CEMETERY or CREMATORY
CHIZURK AMUNO (ARLINGTON) | |
| 24D. LOCATION
BALTIMORE, MARYLAND | | 24E. ADDRESS
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
2 | | 25B. NAME OF REGISTRAR
Robert E. Jaber, M.D. | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|---|---|--|--|--|--|--|
| 69 5751 CERTIFICATE OF DEATH | | | | | REG. NO. 69 5751 | | | | |
| BIRTH NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Charles J. Culleton</i> | | | | | 6-3-69 M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>34 Bon Secours Hospital</i> | | | | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| | | | | | E. STREET AND NUMBER <i>2019 ROLLINGWOOD ROAD</i> | | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>5-11-91</i> | 9. AGE (in years last birthday)
<i>78</i> | If Under 1 Yr. Months: Days: Hours: Min. | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Accountant</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>US Maritime Comm.</i> | | | 11. BIRTHPLACE (State or foreign country)
<i>New York</i> | | | |
| 13. FATHER'S NAME
<i>Michael Culleton</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Annie Donohue</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>yes WWI</i> | | | 16. SOCIAL SECURITY NO.
<i>065-10-6214</i> | | 17. INFORMANT
<i>Pts. Chart</i> | | | | |
| 18. <i>4 12 31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive heart failure</i> <i>3 weeks</i> | | | | |
| ANTECEDENT CAUSES | | | | | (B) <i>Arteriosclerotic heart disease</i> <i>years</i> | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (C) _____ | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | <i>Pulmonary emphysema</i> <i>years</i> | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>yes</i> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that <i>(1)</i> <i>(this hospital)</i> attended the deceased from <i>5-14</i> 19 <i>69</i> to <i>6-3</i> 19 <i>69</i> , that <i>(1)</i> <i>(we)</i> last saw the deceased alive on <i>6-3</i> 19 <i>69</i> and that in <i>(my)</i> <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above <i>(1)</i> <i>(We)</i> <i>(did)</i> (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>U. Sangkum</i> | | | | | 23B. DATE SIGNED
<i>6-3-69</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>U. SANGKUM</i> | | | | | 23D. ADDRESS
<i>Bon Secours Hosp. 2025 W. Fayette St.</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>June 5, 1969</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Balto. National Cemetery Baltimore, Maryland</i> | | | 24D. LOCATION (City, town, or county) (State) | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 5 1969</i> | | 25B. NAME OF REGISTRAR
<i>W. E. Taylor, M.D.</i> | | | 25C. FUNERAL DIRECTOR
<i>Funeral Estate Edmondson Ave. Catonsville, Md. 21228</i> | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5752

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
Charles Fulton TURNER | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input checked="" type="checkbox"/> Month Day Year
June 2, 1969 7:55 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
University Hospital (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 2, 1969 | |
| 6. SEX
male | | 7. RACE
white | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland
B. COUNTY
21-01 | |
| 9. DATE OF BIRTH
Jan. 29, 1903 | | 10. AGE (In years last birthday)
66 | |
| 11. BIRTHPLACE (State or foreign country)
Gambrills, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Gettysburg Turner | | 14. STREET AND NUMBER
773 W. Cross Street | |
| 15. MOTHER'S MAIDEN NAME
Ida Hood | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
No None | |
| 17. SOCIAL SECURITY NO.
212-07-6727 | | 18. INFORMANT
Mrs. Thelma M. Turner (wife) Same as #9 | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Cardiovascular Disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION
0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
No | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE: Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type): Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 6/3/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
June 6, 1969 | |
| 24C. NAME OF CEMETERY or CREMATORY
Glen Haven Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Glen Burnie, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
Singleton Funeral Home | | ADDRESS
Glen Burnie, Md. | |

X

Handwritten signature or initials, possibly "J. B. Acord".

Handwritten signature or initials, possibly "C. B. Acord".

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5753

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD CAIRNS

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

June 3, 1969

2:50 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

006. South Chester Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 3, 1969

2:50 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 2-01

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

8-16-1916

10. AGE (In years
and birthday)

82 10/16

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2 S. Chester Street

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Edward Cairns

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

???

15. MOTHER'S MAIDEN NAME

Elizabeth Flynn

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Walter B. Cooke Funeral Home, New York, N.Y.

19.

319.2 + 019.0

CAUSE OF DEATH

Chronic lung disease and far advanced

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

~~NOT TO BE USED FOR IMMEDIATE CAUSE~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) inactive tuberculosis

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/4/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-7-1969

24C. NAME of CEMETERY or CREMATORY

St. John's

24D. LOCATION

(City, town, or county)

(State)

Queens, New York, New York

25A. DATE REC'D BY HEALTH DEPT.

JUN 5 1969

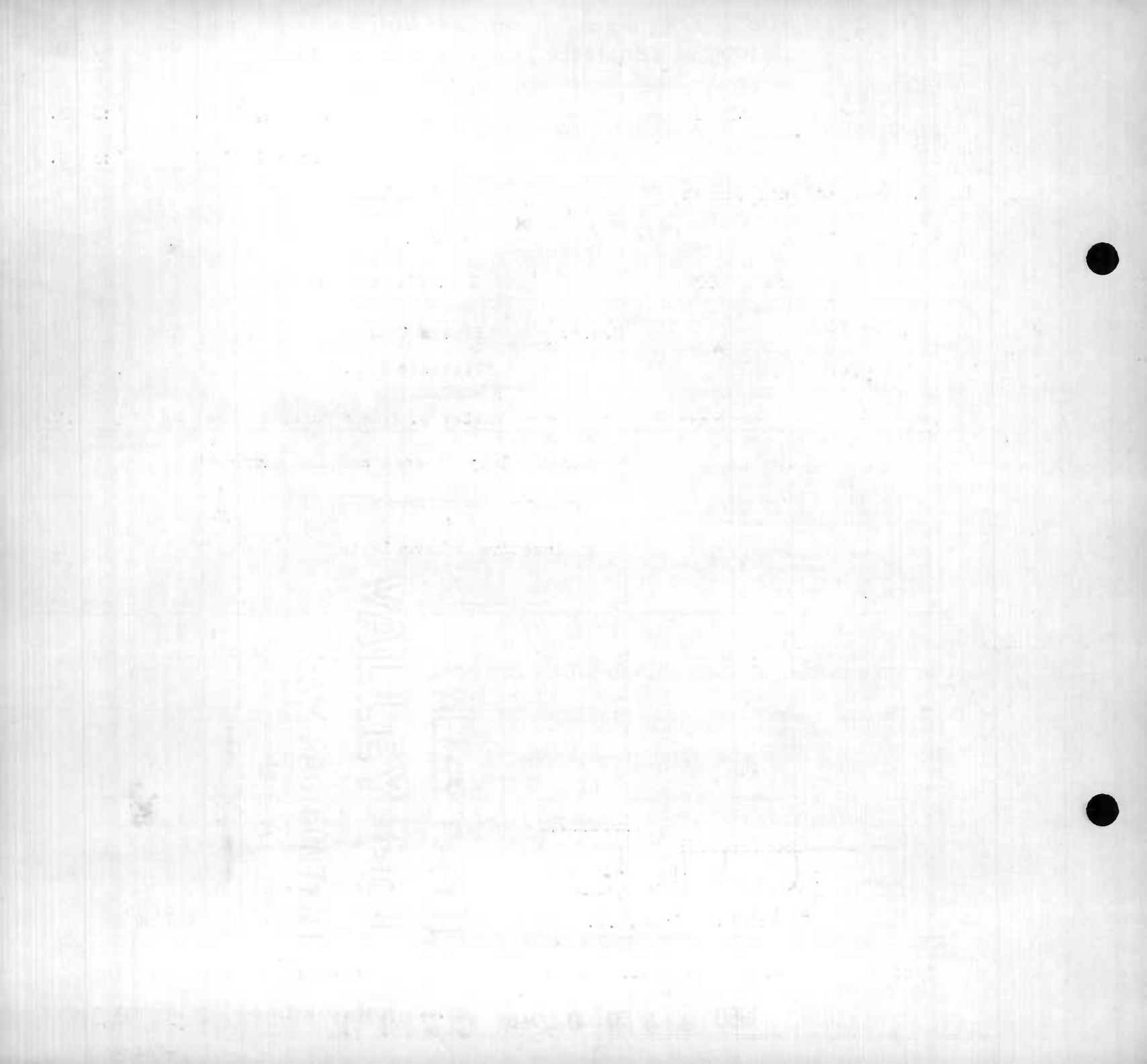
25B. NAME OF REGISTRAR

Robert E. Talley, M.D.

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks Towson, 1050 York Road
Towson, Maryland

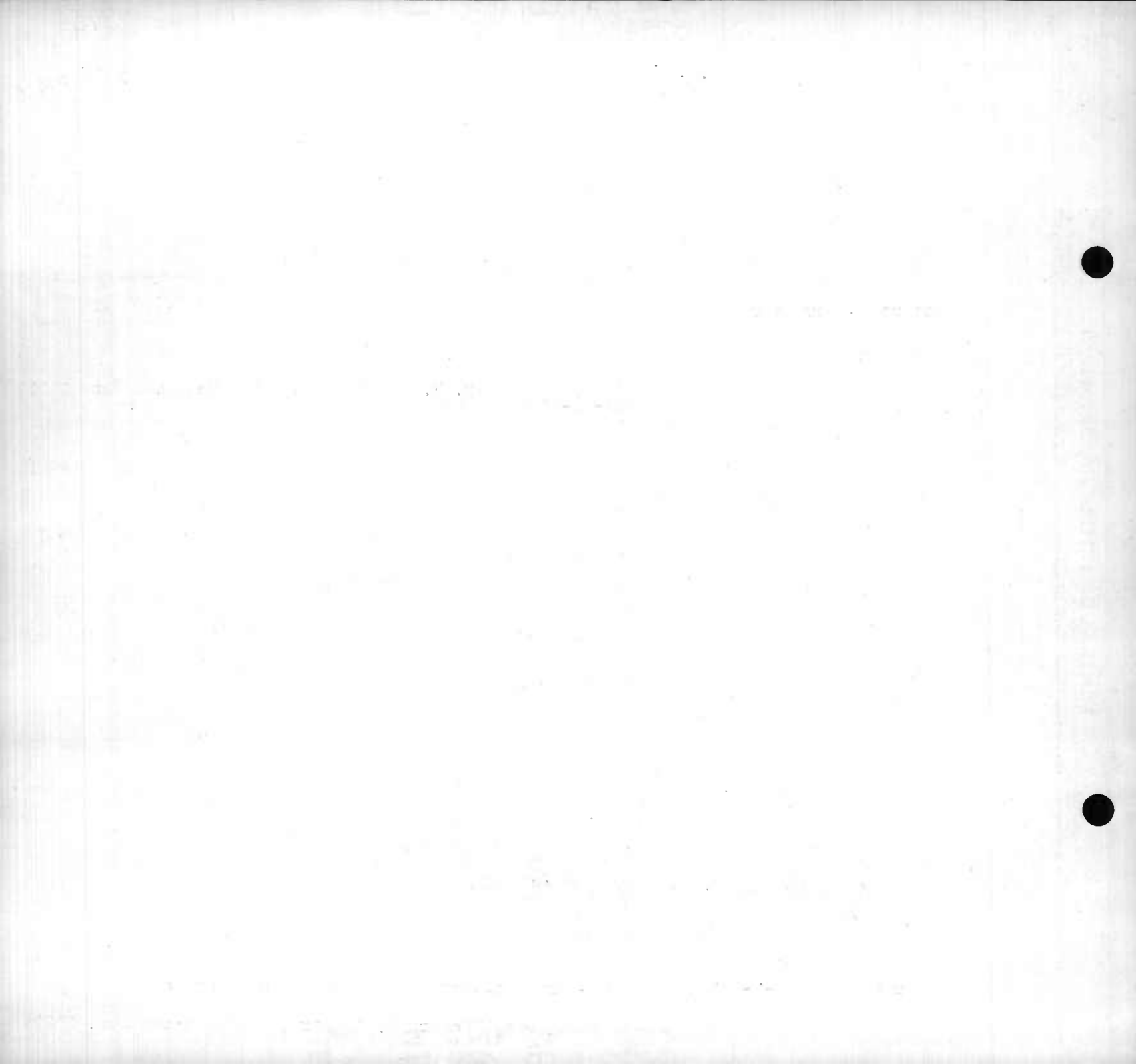
ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. |
|--|------------------------------|---|---|---|
| 1. NAME OF DECEASED
(Type or Print) VIRGINIA K. COLE | | 2. DATE AND HOUR OF DEATH
6.3.69 4:55 PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
BON SECOURS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto.
C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 1217 Ten Oaks Rd. 21227 | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-19-1893 |
| 9. AGE (In years last birthday) 76 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Supervisor | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Joseph P. Dailly | | |
| 14. MOTHER'S MAIDEN NAME
Mary S. Shorten | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO.
215-05-1389 | | 17. INFORMANT
Mr. F. Kenneth Cole, 1217 Ten Oaks Road 21227
XXXXXXXX | | |
| 18. 444.121
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
MESENTERIC THROMBOSIS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) MULTIPLE EMBOLI
DUE TO, OR AS A CONSEQUENCE OF:
5 days | | |
| (C) CARDIAC ARRHYTHMIA | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
ASCVD | | | | |
| 19A. DATE OF OPERATION
6.2.69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
MESENTERIC THROMBOSIS | | 20A. AUTOPSY? (Yes or No)
NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (1) <u>this hospital</u> attended the deceased from 6.2.69 19 to 6.3.69 19, that (1) <u>we</u> last saw the deceased alive on 6.3.69 19 and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>We</u> (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Roberto Ferrer MD | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type)
ROBERTO FERRER MD | | 23D. ADDRESS
Bon Secours Hosp. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
6-7-1969 | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemetery | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
James E. Taylor, R.D. | 25C. FUNERAL DIRECTOR
Howard H. Hubbard | |
| ADDRESS
4107 Wilkens Ave. 21229 | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5755 CERTIFICATE OF DEATH

REG. NO. 69 5755

| | | | |
|--|-------------------------|--|--|
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) PETER COARD | | MAY 31, 1969 10:25 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 10-02 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
90 Ashburton Nursing Home | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
922 N. EDEN ST. | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-20-85 9. AGE (In years last birthday) 84 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Refined | | 10B. KIND OF BUSINESS OR INDUSTRY
None | 11. BIRTHPLACE (State or foreign country)
S. Carolina |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Unknown | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Eddie Coard 834 McHugh St. | |
| 18. 410.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CORONARY THROMBOSIS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 19, 1969 to May 31, 1969 , that (I) (we) last saw the deceased alive on May 28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Abraham B. Hurwitz M.D. | | 23B. DATE SIGNED
June 1, 1969 | |
| 23C. PHYSICIAN'S NAME (Type)
ABRAHAM B. HURWITZ M.D. | | 23D. ADDRESS
7501 Liberty Road, Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-5-69 | |
| 24C. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 5 1969 | | 25B. NAME OF REGISTRAR
Robert E. Gable, M.D. | |
| 25C. FUNERAL DIRECTOR
Edith Or W. Wilson | | ADDRESS
1000 Bunting Ave | |

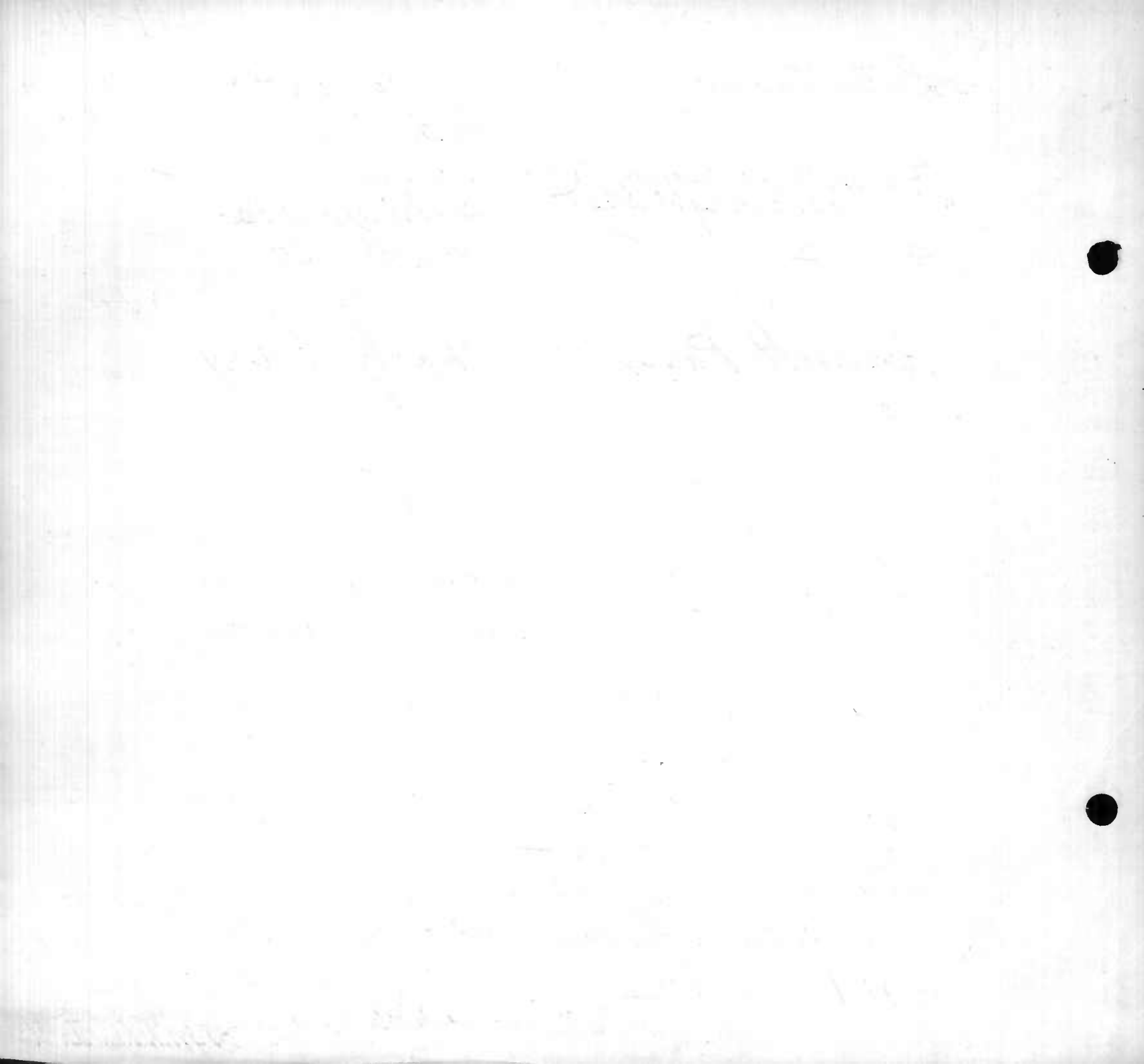
Edg. Gov. 834 Mr. W. 21

W. 21

W. 21

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

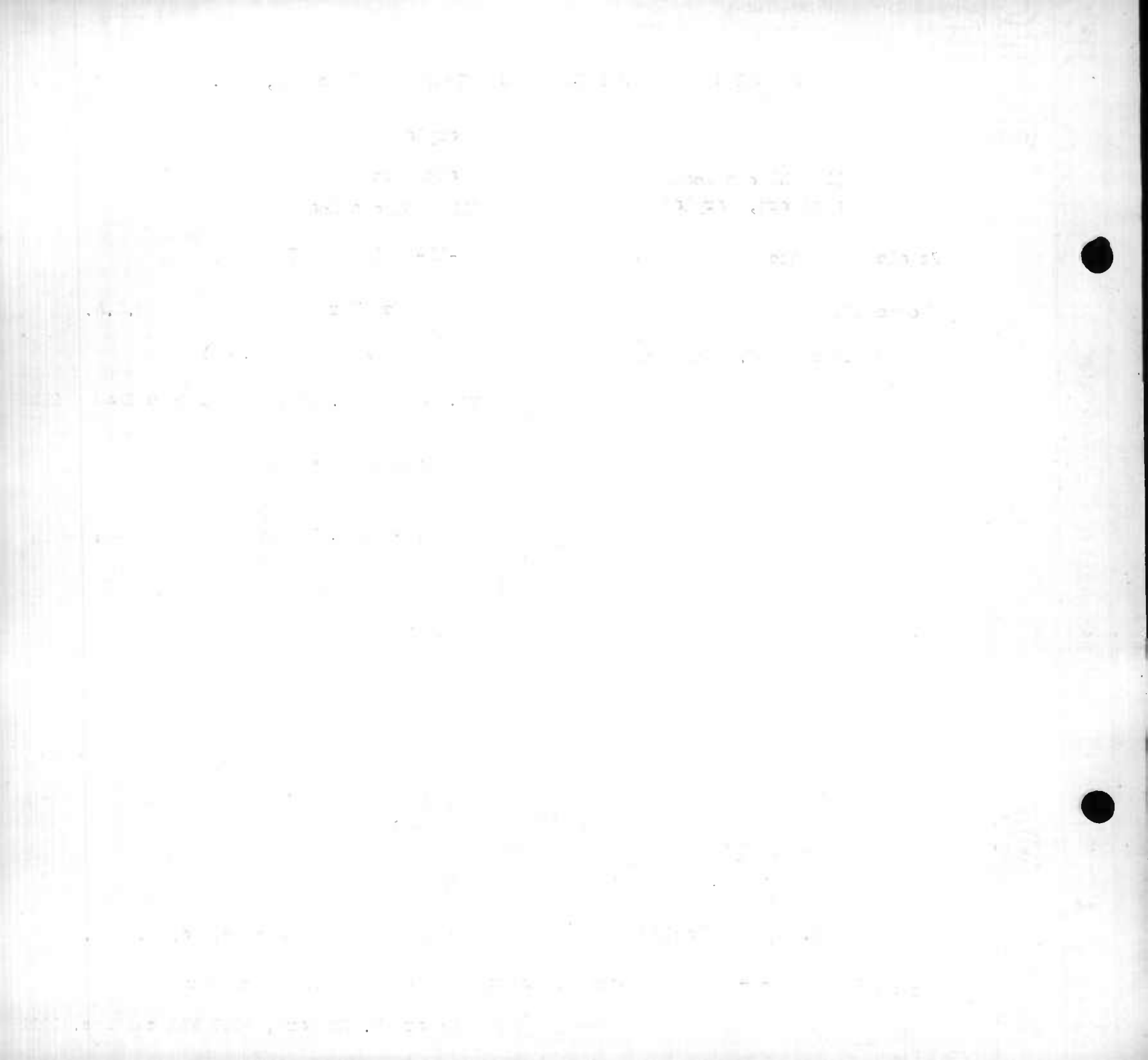
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5757 | |
|---|------------------------------------|---|---|---|---|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED
(Type or Print)</p> <p style="text-align: center;">ADELAIDE SOPHIA SCHNEIDER</p> </div> <div> <p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;">June 3, 1969 3 P.M.</p> </div> </div> | | | | | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>60 4336 Eldone Road
Baltimore, Maryland</p> | | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY <u>25-41</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>4336 Eldone Road</u></p> | | |
| <p>5. SEX</p> <p>Female</p> | <p>6. RACE</p> <p>White</p> | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH</p> <p>9-23-1881</p> | <p>9. AGE (In years lost birthday)</p> <p>87</p> | <p>If Under 1 Yr. Months: Days: Hours: Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>Housewife</p> | | | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> | | <p>11. BIRTHPLACE (State or foreign country)</p> <p>New York</p> |
| <p>12. CITIZEN OF WHAT COUNTRY?</p> <p>U.S.A.</p> | | | <p>13. FATHER'S NAME</p> <p>Dietrich J. Neibuhr</p> | | |
| <p>14. MOTHER'S MAIDEN NAME</p> <p>Sophia (Unknown)</p> | | | <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>No</p> | | |
| <p>16. SOCIAL SECURITY NO.</p> | | | <p>17. INFORMANT ADDRESS</p> <p>Mrs. Lillian A. Lee, 4336 Eldone Road 21229</p> | | |
| <p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>412.41</p> <p>Antecedent Causes</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>Coronary failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>3 days</u></p> <p>(B) <u>Arteriosclerotic C-V-D</u> DUE TO, OR AS A CONSEQUENCE OF: <u>under</u></p> <p>(C) <u>Age</u></p> | | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p><u>Jaundice</u></p> | | | | | |
| <p>19A. DATE OF OPERATION</p> <p>0</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No)</p> | |
| <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | | <p>(If In Baltimore City, give exact location)</p> | | | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p><input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR?</p> | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p> <p>(APPROX.)</p> | | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>6/3</u> <u>1968</u> <u>to</u> <u>6/3</u> <u>1969</u>, that (I) (we) last saw the deceased alive on <u>5/19</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE</p> <p><u>Chris Koenig</u></p> | | | | <p>23B. DATE SIGNED</p> <p><u>6/4/69</u></p> | |
| <p>23C. PHYSICIAN'S NAME (Type)</p> <p>Dr. Cliff Ratliff</p> | | | | <p>23D. ADDRESS</p> <p>4605 Edmondson Avenue, Balto., Md.</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p>Burial</p> | | <p>24B. DATE</p> <p>6-6-1969</p> | | <p>24C. NAME OF CEMETERY or CREMATORY</p> <p>Lutheran Cemetery</p> | |
| <p>24D. LOCATION (City, town, or county) (State)</p> <p>Queens, New York</p> | | <p>25A. DATE REC'D BY HEALTH DEPT.</p> <p>JUN 5 1969</p> | | | |
| <p>25B. NAME OF REGISTRAR</p> <p><u>James E. Fisher, M.D.</u></p> | | <p>25C. FUNERAL DIRECTOR ADDRESS</p> <p>Howard H. Hubbard, 4107 Wilkens Ave. 21229</p> | | | |



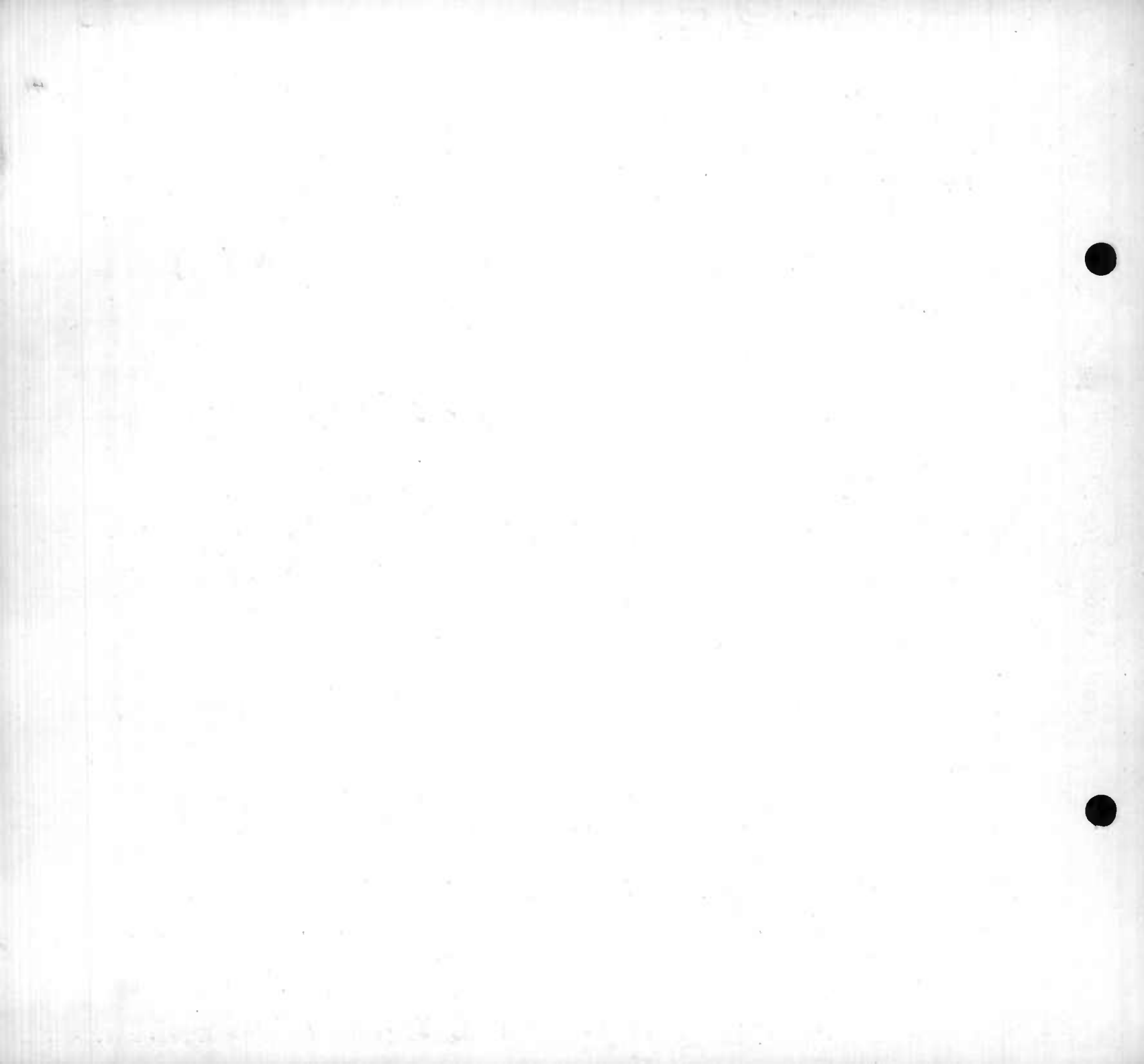
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 5758 CERTIFICATE OF DEATH

REG. NO. 69 5758

| | | | | | |
|--|---------------------|--|-------------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) LUCY R Wilson | | 2. DATE AND HOUR OF DEATH
6-2-69 2:40 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY 12-01 | | C. CITY OR TOWN Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
HARBOR VIEW Conv'l. Center | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
831 Leadenhall ST. 21230 | |
| 5. SEX
F | 6. RACE
N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/5/1900 | 9. AGE (In years lost birthday) 68 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SW | | 10B. KIND OF BUSINESS OR INDUSTRY
Ind | | 11. BIRTHPLACE (State or foreign country)
Ind | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
John Young 831 Leadenhall St | |
| 18. 440.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Pneumonia
(B) Chronic bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF:
(C) arteriosclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
years
years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 5/2 19 69 to 6/2 19 69 , that (I) (we) last saw the deceased alive on 6/2 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
ALLAN A. MACHT MD | | 23B. DATE SIGNED
6/2/69 | | 23C. PHYSICIAN'S NAME (Type)
ALLAN A. MACHT MD | |
| 23D. ADDRESS
21230 | | 23E. NAME OF REGISTRAR
Robert E. Galt, M.D. | | 23F. FUNERAL DIRECTOR
108 W. 1st St. in Montgomery | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/7/69 | | 24C. NAME OF CEMETERY or CREMATORY
mt Auburn Ct | |
| 24D. LOCATION (City, town, or county) (State)
Balt City | | 24E. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 24F. ADDRESS
108 W. 1st St. in Montgomery | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

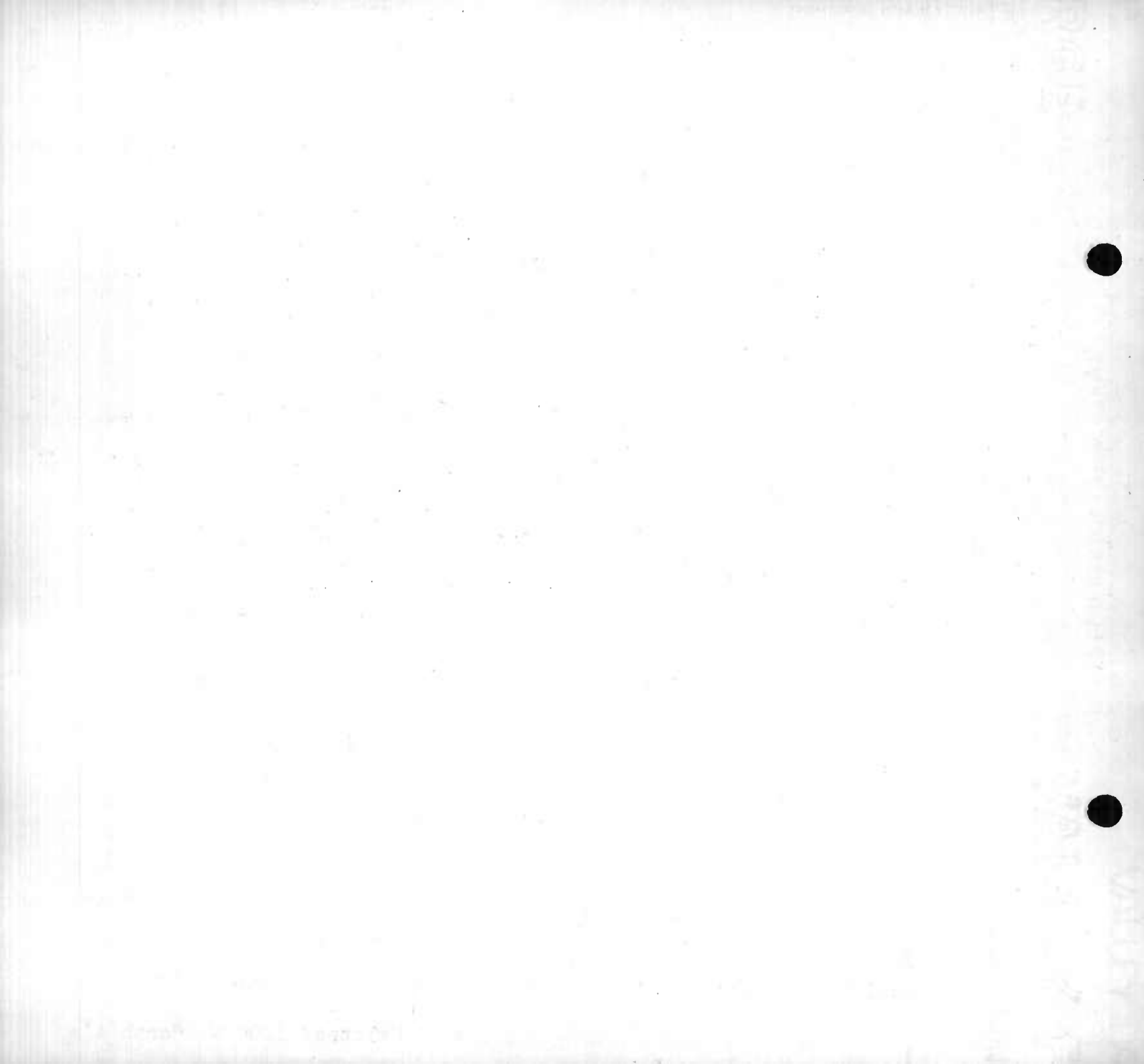
| | | | | | | | |
|--|------------------|---|--|--|---------------------------------------|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | CLARA TAYLOR | | 2. DATE AND HOUR OF DEATH
JUNE 5 1969 5:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
33 THE JOHNS HOPKINS HOSPITAL | | | | MD. | | 8-02 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
1748 N. Gay STREET | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8-17-12 | 9. AGE (In years last birthday)
56 | 10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Lawrenceville, Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
STEVEN RAVIS | | | |
| 14. MOTHER'S MAIDEN NAME
MAMIE GREEN | | | | 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
166-28-0001 | | | | 17. INFORMANT Mary A. Manning
3818 Park Hgts. Ave. Balto., Md. 21215 | | | |
| 18. 156.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
PENAL FAILURE | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE Cerebral Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF:
(B) METASTATIC CA OF GALL BLADDER
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19A. DATE OF OPERATION
5/22/69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
METASTATIC CANCER | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NA | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)
NA | | 21C. WHERE DID INJURY OCCUR?
NA | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
NA | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
NA | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/6 19 69 to 6/5 19 69 that (I) (we) last saw the deceased alive on 6/5 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Vernon T. Tolo, M.D. | | | | 23B. DATE SIGNED
6-5-69 | | 23C. PHYSICIAN'S NAME (Type)
VERNON T. TOLO M.D. | |
| 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Transit-Burial | | 24B. DATE
6-8-69 | | 24C. NAME OF CEMETERY or CREMATORY
Poplar Mt. Bapt. Church Ceme. | | 24D. LOCATION (City, town, or county) (State)
Lawrenceville, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
John C. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Brown Funeral Service | | ADDRESS
Lawrenceville, Virginia | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

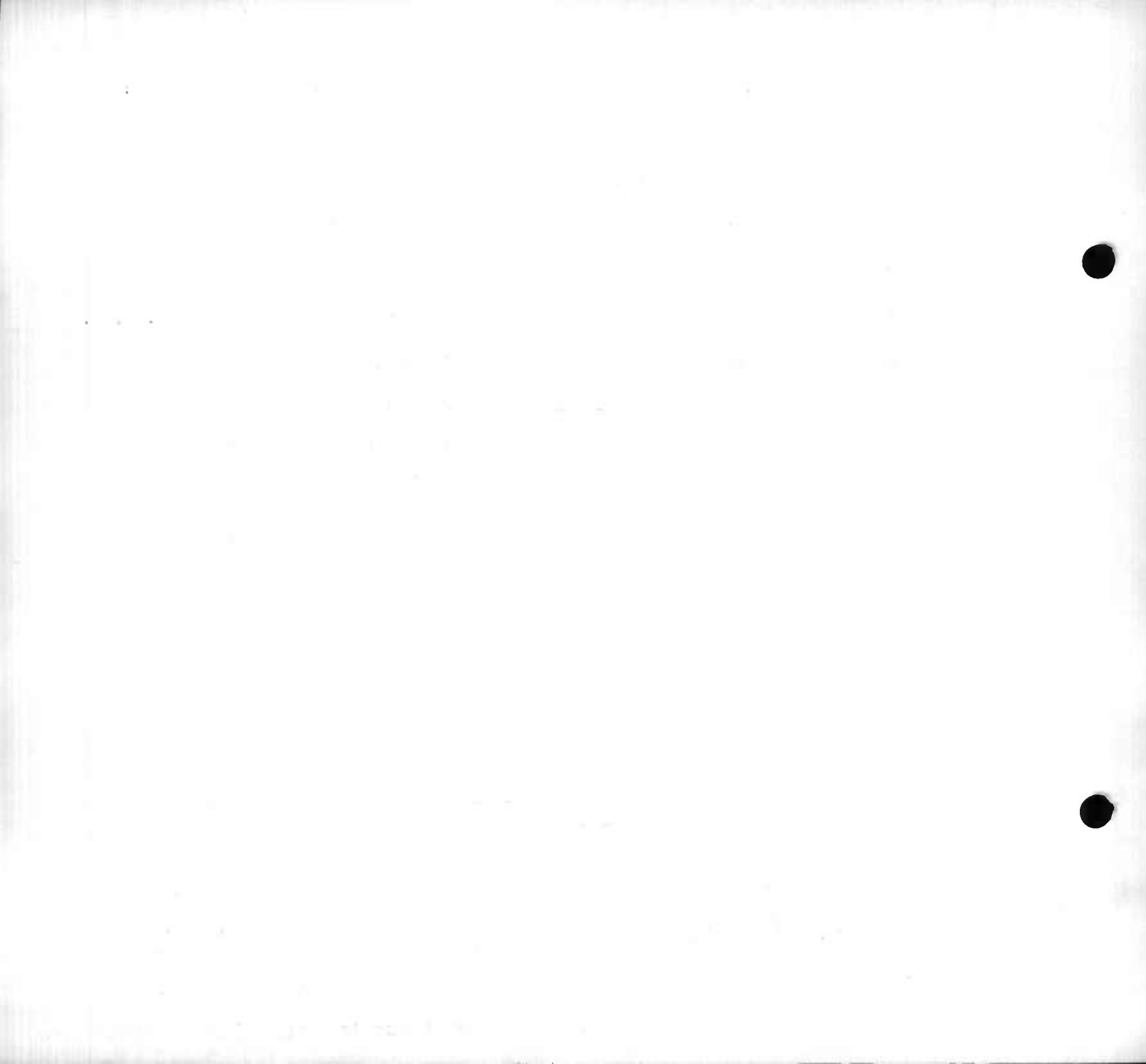
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5760 | |
|---|-----------------------------|---|---|--|---|
| BIRTH NO. 69 5760 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) FRED MINICK | | | 2. DATE AND HOUR OF DEATH
6/1/69 10:40 pm M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY 11-01 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
MARYLAND GENERAL HOSPITAL | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
110 E. PRESTON ST | | |
| 5. SEX
MALE | 6. RACE
CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/10/15 | 9. AGE (In years lost birthday)
53 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY
Cemetery | | 11. BIRTHPLACE (State or foreign country)
MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
EARL MINICK | | |
| 14. MOTHER'S MAIDEN NAME
MARY BLUCHER | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | |
| 16. SOCIAL SECURITY NO.
170 18 2651 | | | 17. INFORMANT
PATIENT - PREV. ADM. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
1890 I BRONCHOPNEUMONIA, MASSIVE
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
CAUSE OF DEATH
CARCINOMA of LUNG, METASTASIS
17R.
to Carcinoma metastatic | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr. | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
CHRON. OBSTRUCTIVE LUNG DISEASE | | | | | |
| 19A. DATE OF OPERATION
5/31/69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Acute Abdomen | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/30 1969 to 6/1/69 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
James Hamby MD | | | 23B. DATE SIGNED
6-2-69 | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS
Halstead 1206 W North Ave | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/6/69 | | 24C. NAME of CEMETERY or CREMATORY
Mt Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
A A County MD | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Talley, M.D. | | 25C. FUNERAL DIRECTOR
Halstead | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 69 5761 | | REG. NO. 69 5761 | |
|--|-------------------------|---|-----------------------------------|--|--|---|---|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Teasley, Viola | | | | 2. DATE AND HOUR OF DEATH
6-4-69 1:00 p.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 14-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
39 Provident Hospital
1514 Division Street
Baltimore, Maryland 21217 | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
1614 McCulloh Street | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | | 9. AGE (In years last birthday)
57 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
John Henry Beverly | | | | 14. MOTHER'S MAIDEN NAME
Blanche | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
216-10-1245 | | 17. INFORMANT
Willie Teasley (Husband) | | ADDRESS
SAME | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Atrial Fibrillation | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-18-69 to 6-4-69 19____ to ____ 19____
that (I) (we) lost saw the deceased alive on 6-4-69 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Gregorio Tengco | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
6-4-69 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Gregorio Tengco | | | | 23D. ADDRESS
Provident Hospital, Inc.
1514 Division Street - Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/9/69 | | 24C. NAME OF CEMETERY or CREMATORY
Oakwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Richmond Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Adolphus Halstead ADDRESS 1206 W North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. |
|---|--|---|--|--|
| BIRTH NO. | | 69 5762 | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) | | Johnson Lucille | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 2. DATE AND HOUR OF DEATH
6-5-69; 10-45 A. M. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
2103 M ^C CULLOH ST. 14-03 | | |
| Lutheran Hospital of Maryland
46 | | C. CITY OR TOWN D. INSIDE CITY LIMITS?
Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX
Female | | E. STREET AND NUMBER
930, Ashburne Street. | | |
| 6. RACE
COL. | | 8. DATE OF BIRTH
NO. 4 DAY NOT KNOWN - YR 1883 | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years lost birthday)
86 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
DOMESTIC | | 11. BIRTHPLACE (State or foreign country)
VA. | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME
NOT KNOWN | | 14. MOTHER'S MAIDEN NAME
NOT KNOWN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
219-30-6910 | | |
| 17. INFORMANT
SARAH BROWN - 2103 M ^C CULLOH ST. | | ADDRESS | | |
| 18. 44519 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Gangrene RA. foot
(B) Gangrene Rt. foot
(C) | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 5-23-1969 to 6-5-1969, that (I) (we) last saw the deceased alive on 5-6-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did-not) view the body after death. | | | | |
| 23A. SIGNATURE
1c/shah M.D. | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type)
Shah Kantilal Techandbhai M.D. |
| 23D. ADDRESS
Lutheran Hospital
730 Ashburne St - Baltimore | | 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | |
| 24B. DATE
6/9/69 | | 24C. NAME OF CEMETERY or CREMATORY
ARBUTUS MEM. PK. | | 24D. LOCATION (City, town, or county) (State)
BALTO., COUNTY - MD. |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
Robert E. Bailey, M.D. | | 25C. FUNERAL DIRECTOR
B. BROWN 3106 WALBRIDGE AVE |

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5763</u> | |
|---|---------------------|---|-------------------------------------|---|--|
| BIRTH NO. <u>69 5763</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>Mary Hancock</u> | | 2. DATE AND HOUR OF DEATH
<u>Mary 30 1969 0730AM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>37 Mercy Hospital</u> | | A. STATE
<u>MARYLAND</u> | | B. COUNTY
<u>16-08</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>728 GRANTLEY ST</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10-31-08</u> | 9. AGE (In years last birthday)
<u>60</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>DOMESTIC</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | |
| 13. FATHER'S NAME
<u>BASIL JACKSON</u> | | 14. MOTHER'S MAIDEN NAME
<u>ALICE HAWKINS</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>212-03-9529</u> | | 17. INFORMANT
<u>Wm HANCOCK 728 GRANTLEY ST.</u> | |
| 18. <u>162.1 I</u> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CARDIOPULMONARY FAILURE | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>TERMINAL CARCINOMA</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>CARCINOMA LUNG</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Metastasis to liver</u>
<u>hepatic fatty infiltration of liver</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>48 hrs.</u> | | | |
| 19A. DATE OF OPERATION
<u>04/3/69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>(C)</u> | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/31/69</u> 19 to <u>5/30/1969</u> that (I) (we) last saw the deceased alive on <u>5/29/69</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | | | 23B. DATE SIGNED
<u>30 May 69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>[Signature]</u> | | | | 23D. ADDRESS
<u>[Signature]</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>6-5-69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Mt. Auburn Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Balt., Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 6 1969</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Charles B. Davis</u> | | | |
| 25D. ADDRESS
<u>839 Mt. Holly St</u> | | | | | |



5-420

69 5764 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5764

REG. NO.

BIRTH NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
EULA SCHELHAUSE | | | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
6 4 69 9:35 a.m. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
3137 Abell Ave. | | | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 4, 1969 9:35 a.m. | | | |
| 6. SEX
Female | | | | 7. RACE
White | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
9-10-1895 | | | | 10. AGE (In years last birthday)
80 73 | | 11. BIRTHPLACE (State or foreign country)
Canada | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | 13. FATHER'S NAME
Ukn. | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 14B. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 15. MOTHER'S MAIDEN NAME
Ukn. | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 17. SOCIAL SECURITY NO.
X | | | | 18. INFORMANT
523 Annabel Ave. Elmer Schelhouse Balto. md. 21225 | | | |
| 19. CAUSE OF DEATH
412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION
0 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 21. AUTOPSY? (Yes or No)
No | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

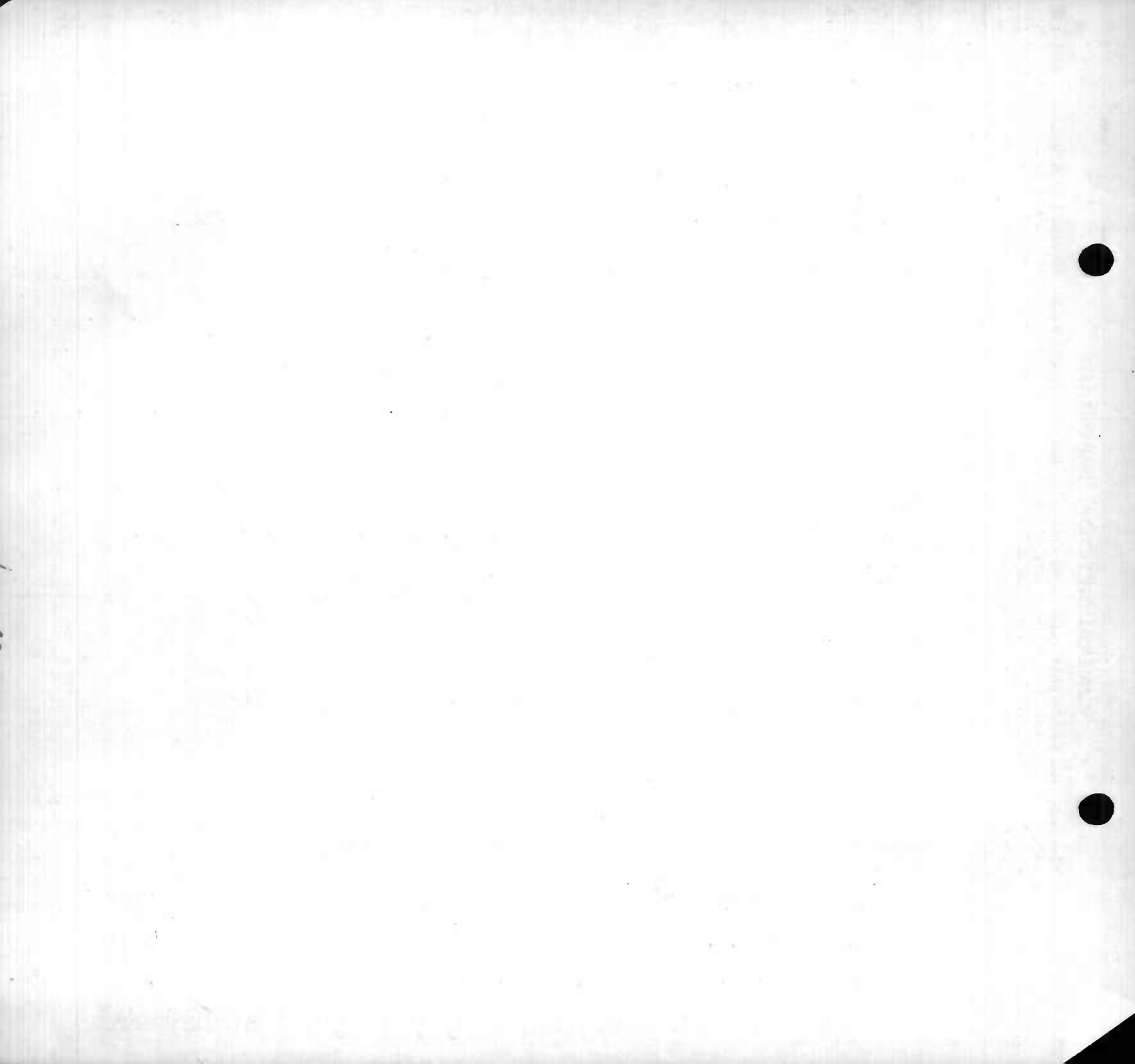
ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 4, 1969
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-7-1969 | | 24C. NAME OF CEMETERY OR CREMATORY
Glen Haven Cemetery | | 24D. LOCATION (City, town, or county) (State)
Glen Burnie, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
Wm. E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
McCully 5130 E. Fort Ave 21230 | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

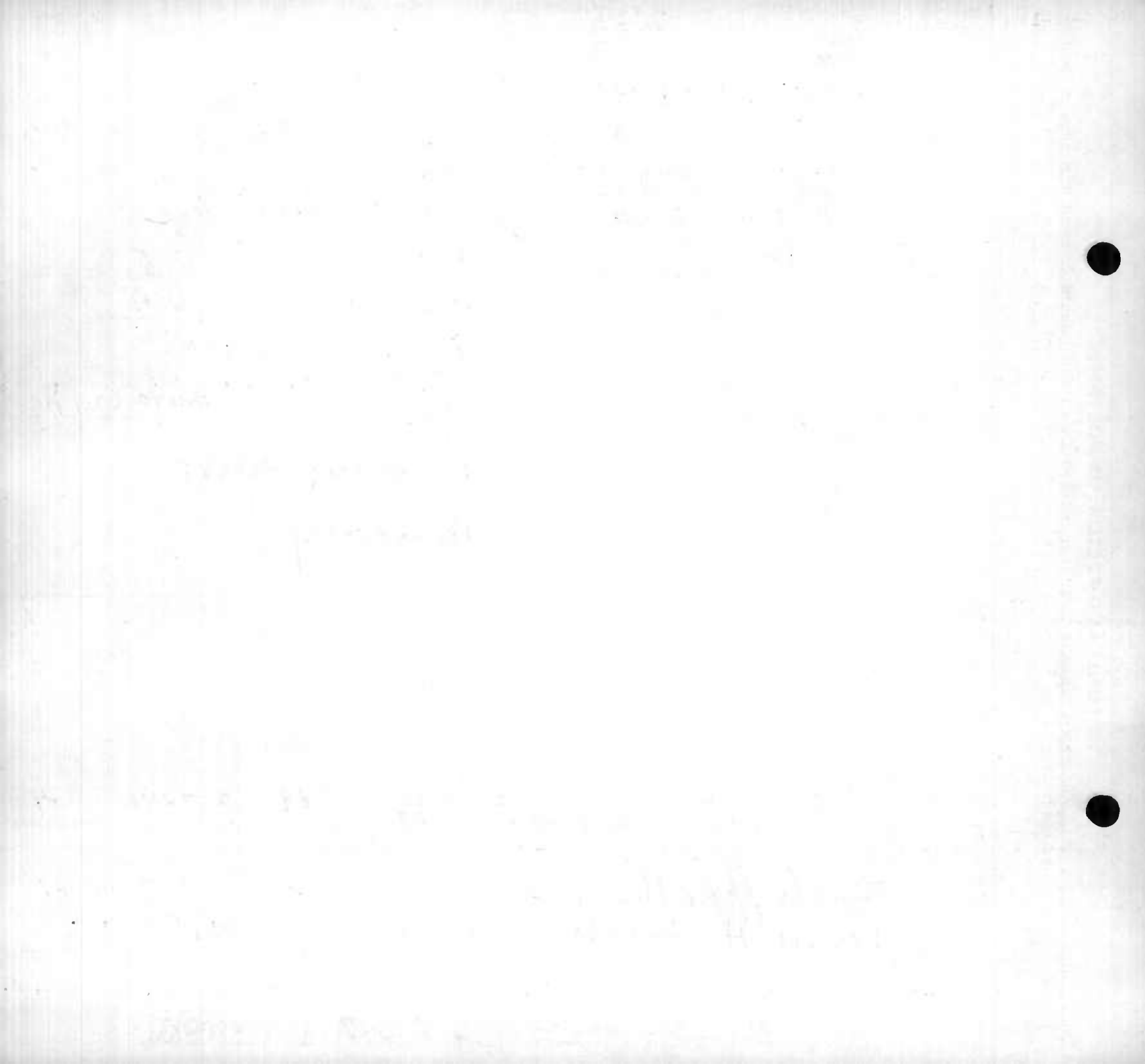
| 54-29-47 bjs R-163 69 5765 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5765 4 | |
|--|--|--|--|---|--|---|--|
| BIRTH NO. 69-09127 | | | | 1. NAME OF DECEASED
(Type or Print) Roberts, Baby Boy | | 2. DATE AND HOUR OF DEATH
MAY 25, 1969 1:55 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY 2-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Baltimore City Hospitals | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
21224 4940 EASTERN AVENUE BALTIMORE, MARYLAND | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
Male | | 6. RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MAY 25, 1969 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years lost birthday)
1 | | 11. BIRTHPLACE (State or foreign country)
U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME
ROSEMARY DICKERSON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
BCH: RECORDS 4940 EASTERN AVE. BALTO. MD. | | ADDRESS
21224 | |
| 18. 775.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cardiac Arrest | | | | CAUSE OF DEATH
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Erythroblastosis Fetalis - & Hydrops | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
Rh - incompatibility | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 25 12:55 AM 1969 to MAY 25 1:55 AM 1969 , that (I) (we) lost saw the deceased alive on MAY 25 1:55 AM 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
M. Schwarz M.D. | | | | 23B. DATE SIGNED
5/25/69 | | | |
| 23C. PHYSICIAN'S NAME (Type)
M. SCHWARZ M.D. | | | | 23D. ADDRESS
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremated | | 24B. DATE
6/3/69 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore City Hospitals | | 24D. LOCATION (City, town, or county) (State)
4940 Eastern Avenue, Baltimore, Md. 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
Robert E. Jaber, M.D. | | 25C. FUNERAL DIRECTOR
5 7 5 | | HOSPITAL DISPOSAL ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 5766 | | | | BALTIMORE CITY HEALTH DEPT. | | REG. NO. 69 5766 | |
|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) LIVINGSTON, BABY GIRL | | | | 2. DATE AND HOUR OF DEATH
2-JUNE-69 7:25 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 8-05 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 BALTIMORE CITY HOSP
4940 EASTERN AVE
BALTO MD 21224 | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Female 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
28 MAY 69 | | 9. AGE (In years last birthday)
0 5 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME
ROBIN LIVINGSTON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
L. H. KALLEN ADDRESS
RECORDS BCH: 4940 Eastern Ave. BALTO City Hosp | |
| 18. 176-91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
RESPIRATORY ARREST
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
PREMATURITY | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 28 MAY 19 69 to 2 JUNE 19 69 , that (I) (we) lost saw the deceased alive on 2 JUNE 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Lowell H. Kallen MD | | | | 23B. DATE SIGNED
2-JUNE-69 | | 23C. PHYSICIAN'S NAME (Type)
LOWELL H KALLEN | |
| 23D. ADDRESS
4940 Eastern Avenue, Baltimore, Md. BALTO. City Hosp 21224 | | 24. BURIAL CREMATION, REMOVAL (Specify)
Cremated | | | | | |
| 24B. DATE
6/4/69 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore City Hospitals | | 24D. LOCATION (City, town, or county) (State)
4940 Eastern Avenue, Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
W. E. Jones, Jr. | | 25C. FUNERAL DIRECTOR ADDRESS
57 HOSPITAL DISPOSAL | | | |

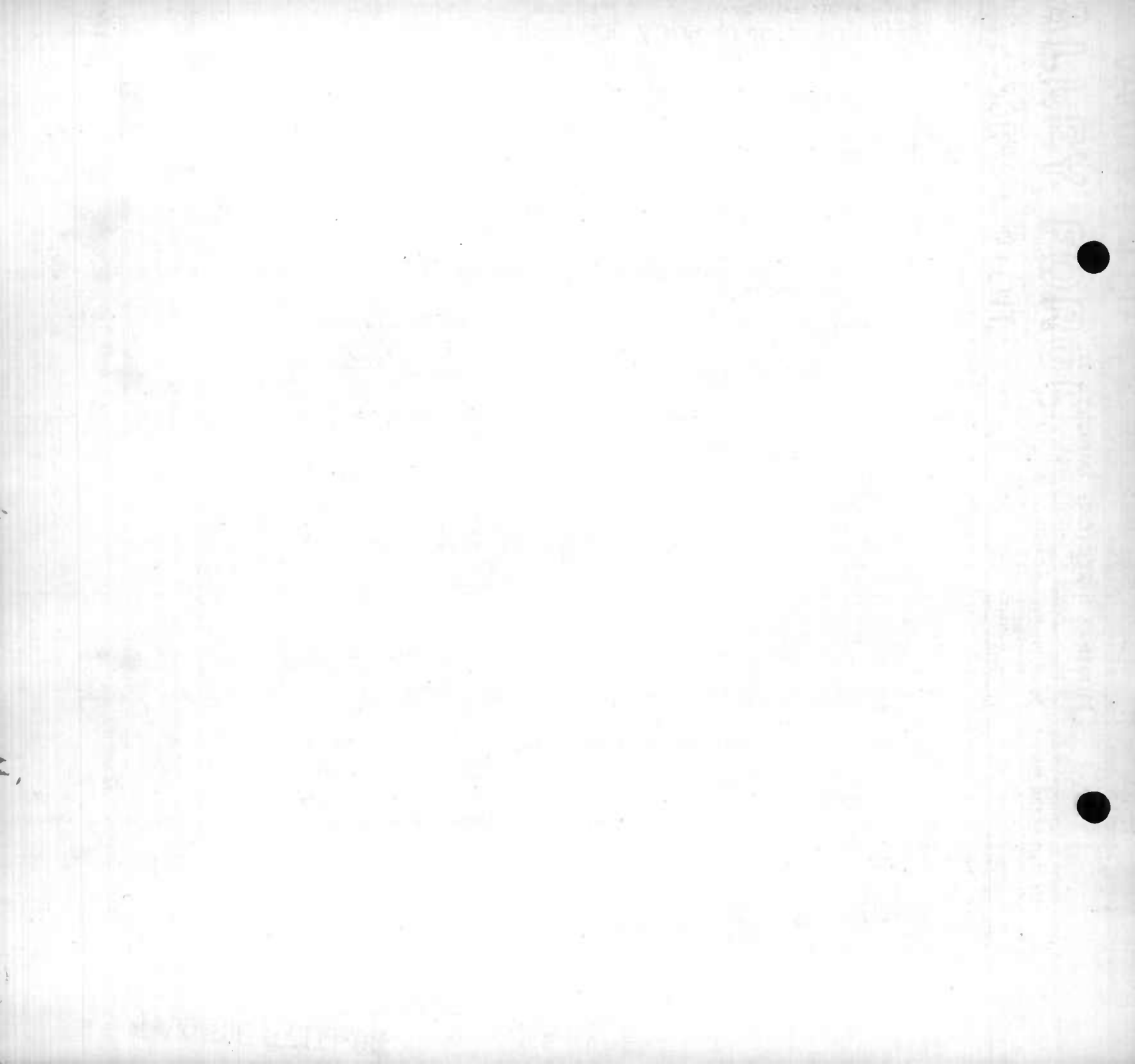


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5767 | |
|---|------------------|---|-----------------------------|---|---|
| BIRTH NO. 69-0905269 5767 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Baby Boy Gilbert | | 2. DATE AND HOUR OF DEATH
5/30/69 1:18 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
31 Balt. City Hospital | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 4940 EASTERN AVE. BALTIMORE, MD. 21224 | | E. STREET AND NUMBER
58 CUTLASS CT. 21221 005 | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/30/69 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min.
7 50 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
JAMES | | 14. MOTHER'S MAIDEN NAME
Evelyn M. WEIR | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
4940 EASTERN AVE.
BCH RECORDS: BALTIMORE, MARYLAND 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF:
(B) Precipitated by ? Reg. Disten
? CNS bleed. Syndrome
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 30 5:30 AM 1969 to MAY 30 1:18 PM 1969, that (I) (we) last saw the deceased alive on MAY 30 1:18 PM 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
M. Schwarz M.D. | | 23B. DATE SIGNED
5-30-69 | | | |
| 23C. PHYSICIAN'S NAME (Type)
MILTON D. SCHWARTZ M.D. | | 23D. ADDRESS
Balt. City Hosp. | | 4940 EASTERN AVE.
BALTIMORE, MD. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
CREMATION | | 24B. DATE
6-3-69 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE CITY HOSPITALS | |
| 24D. LOCATION
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | 24E. NAME OF REGISTRAR
Robert E. Farber, M.D. | | 24F. FUNERAL DIRECTOR
5767 | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR
ADDRESS | |

HOSPITAL DISPOSAL

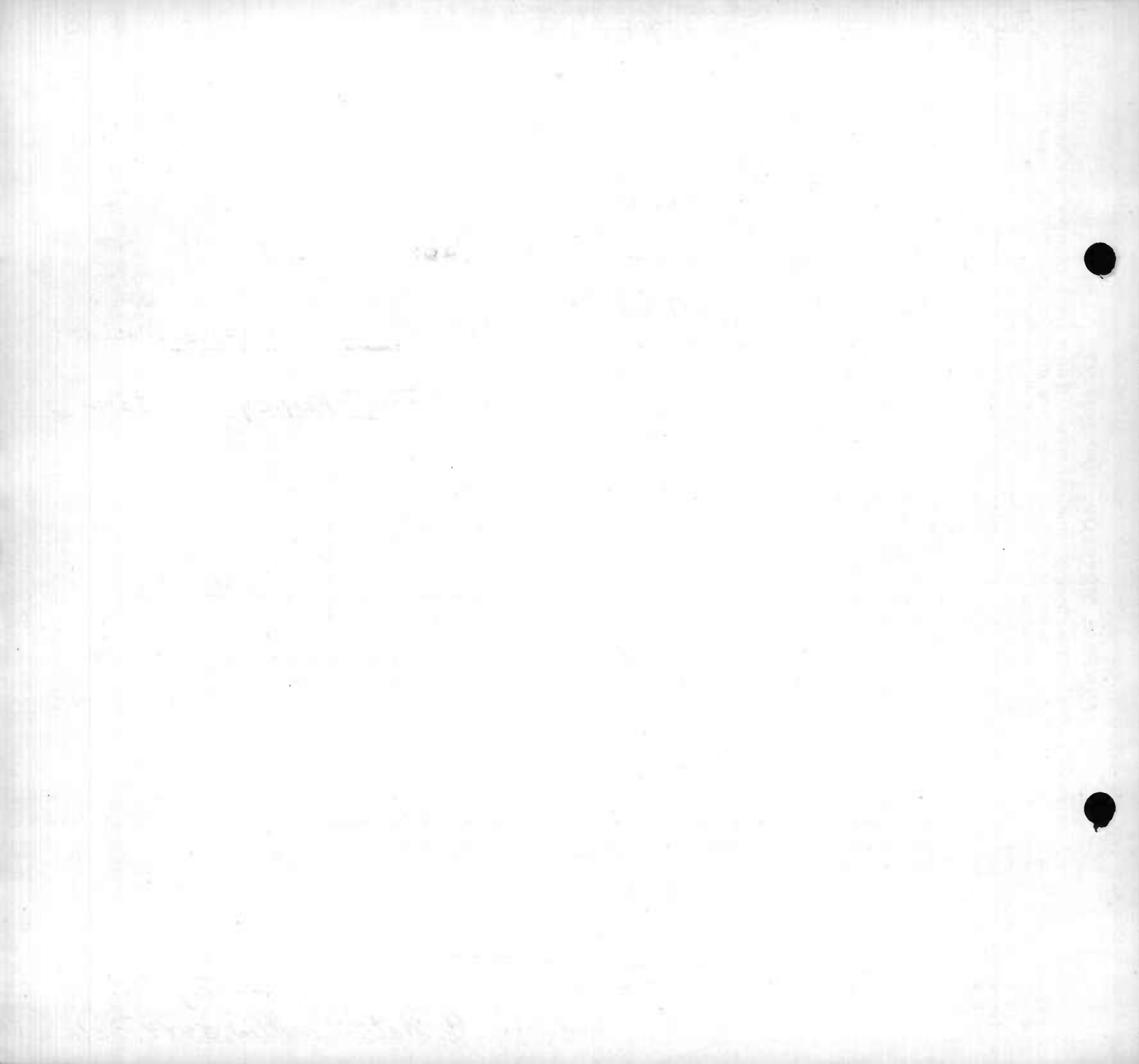


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5768 CERTIFICATE OF DEATH REG. NO. 69 5768

| | | | | | |
|---|--|--|---|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) LENA F. ZENDGRAF | | 2. DATE AND HOUR OF DEATH
June 2, 1969 10:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
35 CHURCH HOME & HOSP. | | | A. STATE MD B. COUNTY USA | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
100 N. BROADWAY | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX F | | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
TEL. OPERATOR | | 10B. KIND OF BUSINESS OR INDUSTRY
C&P TELEPHONE Co. | | 8. DATE OF BIRTH
12/26/04 | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. BALTO., Md. | | 9. AGE (In years last birthday)
64 | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
AMBROSE DENSON | | | 14. MOTHER'S MAIDEN NAME
FRANCES MAZUREK | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
212-05-1244 | | 17. INFORMANT
Patient FAMILY | |
| 18. 183.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
Cardio-Pulmonary Failure | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Cardio-Pulmonary Failure | | | |
| | | (B) Carcinomatosis, peritoneal & pelvic region
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) Rt. Ovarian Carcinoma. | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 30 1969 to June 2 1969 , that (I) (we) last saw the deceased alive on June 2 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. Johnson, M.D. | | | | 23B. DATE SIGNED
6/2/69 | |
| 23C. PHYSICIAN'S NAME (Type)
HONORARY DR. JOHNSON | | | | 23D. ADDRESS
CHURCH HOME & HOSPITAL | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-6-69 | | 24C. NAME OF CEMETERY or CREMATORY
PARKWOOD | |
| 24D. LOCATION (City, town, or county) (State)
BALTO., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 8 1969 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
J. Walter Conklin 5444 BELAIR RD | | | |



FUNERAL DIRECTOR: IMPORTANT

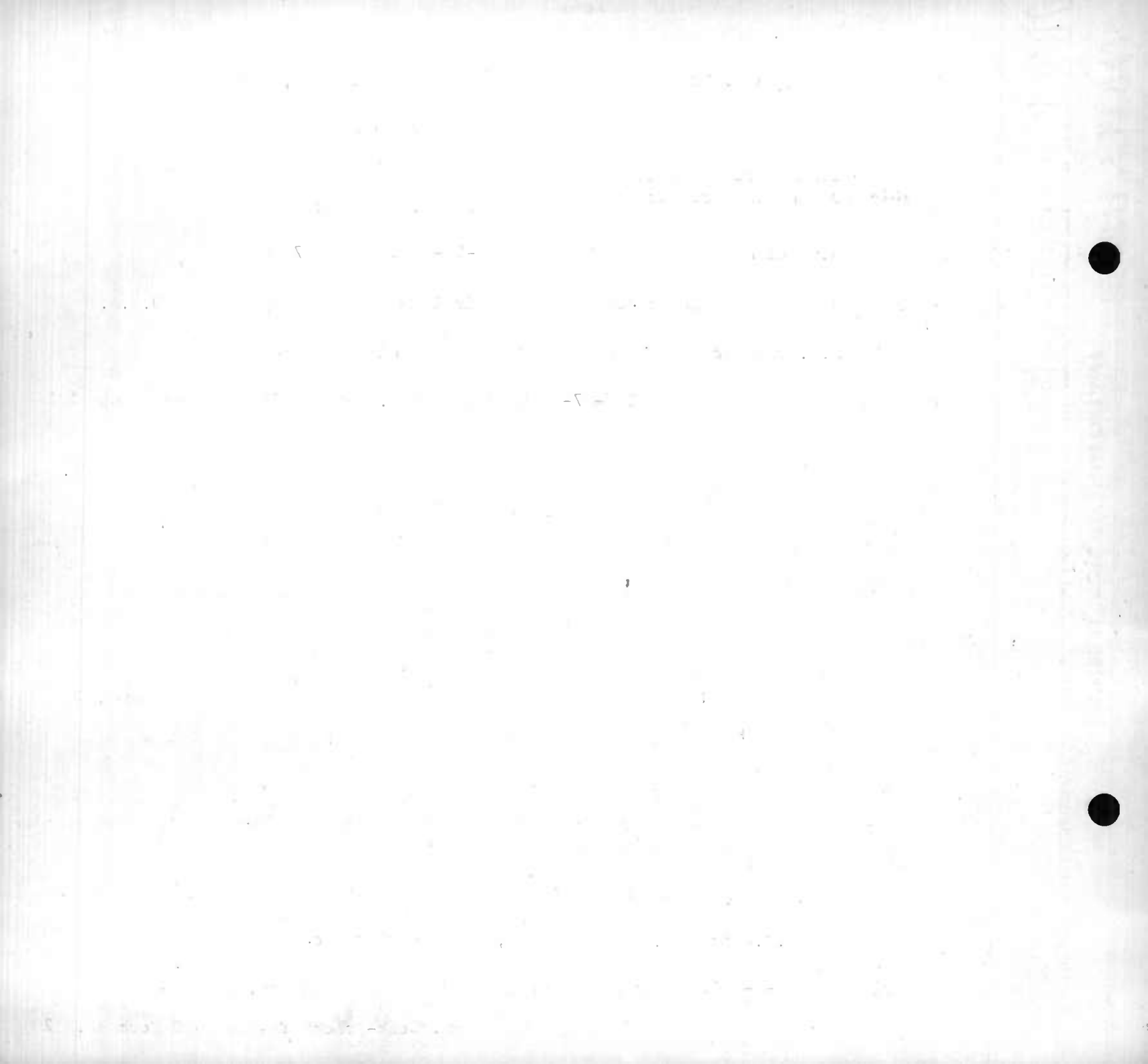
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 5769 CERTIFICATE OF DEATH

REG. NO. 69 5769

| | | | | | |
|---|-----------|--|------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Ruth B. Cromwell | | June 4, 1969 9 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | |
| 44 Union Memorial Hospital
33rd and Calvert Streets | | | | Maryland | |
| | | | | C. CITY OR TOWN | D. INSIDE CITY LIMITS? |
| | | | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | | E. STREET AND NUMBER | |
| | | | | 559 E. 38th Street | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days |
| Female | Caucasian | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 1-29-1895 | 74 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Clerk | | Insurance | | Virginia | |
| 13. FATHER'S NAME | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| J.H. Bramberry | | | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 216-07-0942 | | Kathleen B. Dawson 3611 Woodlea Avenue 21214 | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | 7-14 days | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | Intestinal Obstruction | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | Carcinoma descending | |
| (C) Colon | | | | 1-2 years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-3-69 19 to 6-4-69 19, that (I) (we) last saw the deceased alive on 6-3-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| C.W. Peake M.D. | | | | 6-4-69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| C.W. Peake | | | | 4508 Harford Road | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 6-6-1969 | | Moreland Memorial Park | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D. BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUN 6 1969 | | Charles E. Fisher, M.D. | | Wm. Cook-Brooks Towson 1050 York Rd. 21204 | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5770
REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
MICHAEL DANNIS | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input checked="" type="checkbox"/> June 3, 1969 6:05 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
2828 Oakley Avenue | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 3, 1969 6:05 A.M. | |
| 6. SEX
male | | 7. RACE
white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 27-17 | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday)
57 | |
| 11. BIRTHPLACE (State or foreign country)
RUSSIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SELF EMPLOYED | | 14B. KIND OF BUSINESS OR INDUSTRY
PLUMBER | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO.
219-10-8603 | |
| 18. INFORMANT
MRS. ADRIENNE BAYLIN | | ADDRESS
3052 Essex Rd. #21207 | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Cardiovascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-5-69 | |
| 24C. NAME of CEMETERY or CREMATORY
BETH TFILOH | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. | | ADDRESS
6070 REISTERSTOWN ROAD, BALTO. 21215 | |

SELF EMPLOYED
PLANNED
U.S.A.
UNION
114-10-0001 HON. ROBERT M. LAURENCE, JR. 1001 E. 10TH ST. ST. LOUIS, MO. 63101

WALTER

RECEIVED

1001 E. 10TH ST. ST. LOUIS, MO. 63101

1001 E. 10TH ST. ST. LOUIS, MO. 63101

1001 E. 10TH ST. ST. LOUIS, MO. 63101

1001 E. 10TH ST. ST. LOUIS, MO. 63101

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5771 | |
|---|--------------|---|---|---|--|
| BIRTH NO. | | 69 5771 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Katherine C. Palm | | | 2. DATE AND HOUR OF DEATH
June 3, 1969 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 7-01 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
UNION MEMORIAL HOSPITAL | | | C. CITY OR TOWN
Baltimore | | |
| | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER
2920 E. Madison St. | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 6, 1888 | 9. AGE (In years last birthday)
80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
James J. Gallagher | | 14. MOTHER'S MAIDEN NAME
Mary Stevens | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-50-7470 | | 17. INFORMANT
Robert Palm 2920 E. Madison St. | |
| 18. 433.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
CHRONIC THROMBOSIS
2 HRS. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) CHRONIC ARTERIOSCLEROSIS
3 YRS. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/27 1968 to 6/3 1969, that (I) (we) last saw the deceased alive on 5/20/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
Stuart D. Sunday MD | | | | 23B. DATE SIGNED
6/6/69 | |
| 23C. PHYSICIAN'S NAME (Type)
STUART D. SUNDAY | | | | 23D. ADDRESS
201 E. 33rd St. (21218) | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/7/69 | | 24C. NAME of CEMETERY or CREMATORY
Holy Cross Cemetery | |
| 24D. LOCATION
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
Robert E. Palmer, MD | | 25C. FUNERAL DIRECTOR
Charles L. Stevens Funeral Home, Inc.
1501 East Port Avenue | |

1884

1885

1886

1887

1888

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | | |
|---|--|----------|--|---|--|-------------------|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | | | |
| Robert A. Pfarr | | | | 6/9/69 - 6-4-69 | | | | M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | | | | |
| A. STATE | | | | B. COUNTY | | | | | | | |
| Maryland | | | | 27-35 | | | | | | | |
| 5. CITY OR TOWN | | | | 6. INSIDE CITY LIMITS? | | | | | | | |
| Baltimore | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 7. STREET AND NUMBER | | | | 8. STREET AND NUMBER | | | | | | | |
| 3007 Rosalie Ave | | | | 3007 Rosalie Ave | | | | | | | |
| 9. SEX | | 10. RACE | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 12. DATE OF BIRTH | | 13. AGE (In years last birthday) | | 14. If Under 1 Yr. Months: Days: Hours: Min. | |
| Male | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9/4/15 | | 53 | | | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 16. KIND OF BUSINESS OR INDUSTRY | | | | 17. BIRTHPLACE (State or foreign country) | | | |
| Security Guard | | | | Western Electric | | | | Maryland | | | |
| 18. FATHER'S NAME | | | | 19. MOTHER'S MAIDEN NAME | | | | 20. CITIZEN OF WHAT COUNTRY? | | | |
| | | | | Marie Beckett | | | | U.S.A. | | | |
| 21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 22. SOCIAL SECURITY NO. | | | | 23. INFORMANT | | | |
| Yes War II | | | | 213-09-3364 | | | | Mrs Irene Pfarr | | | |
| 24. ADDRESS | | | | 25. ADDRESS | | | | 26. ADDRESS | | | |
| 3007 Rosalie Ave | | | | 3007 Rosalie Ave | | | | 3007 Rosalie Ave | | | |
| 27. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | 28. CAUSE OF DEATH | | | | 29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | harder Arrest - whole | | | | | | | |
| 30. ANTECEDENT CAUSES | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) chr. Myocardial Insufficiency | | | | | | | |
| 31. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | 32. DATE OF OPERATION | | | | 33. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| II | | | | 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 19A. DATE OF OPERATION | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | | |
| 21F. HOW DID INJURY OCCUR? | | | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/2 to 4/18 1969, that (I) (we) lost saw the deceased alive on 4/18 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Nathan Lannoy M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 6/6/69 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | | | |
| NATHAN Lannoy | | | | 7101 Harford Rd., Balto., Md. 21234 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME OF CEMETERY or CREMATORY | | | |
| Burial | | | | 6/9/69 | | | | Baltimore National | | | |
| 24D. LOCATION (City, town, or county) (State) | | | | 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | |
| 5501 Frederick Rd | | | | JUN 6 1969 | | | | Cook-Zannino | | | |
| 25C. FUNERAL DIRECTOR | | | | 25D. NAME OF REGISTRAR | | | | 25E. FUNERAL DIRECTOR | | | |
| Balto. Md. | | | | Frederick J. Cook | | | | Frederick J. Cook | | | |

Statement from Dr. Nathan Janney,
attending Physician 6-9-69 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

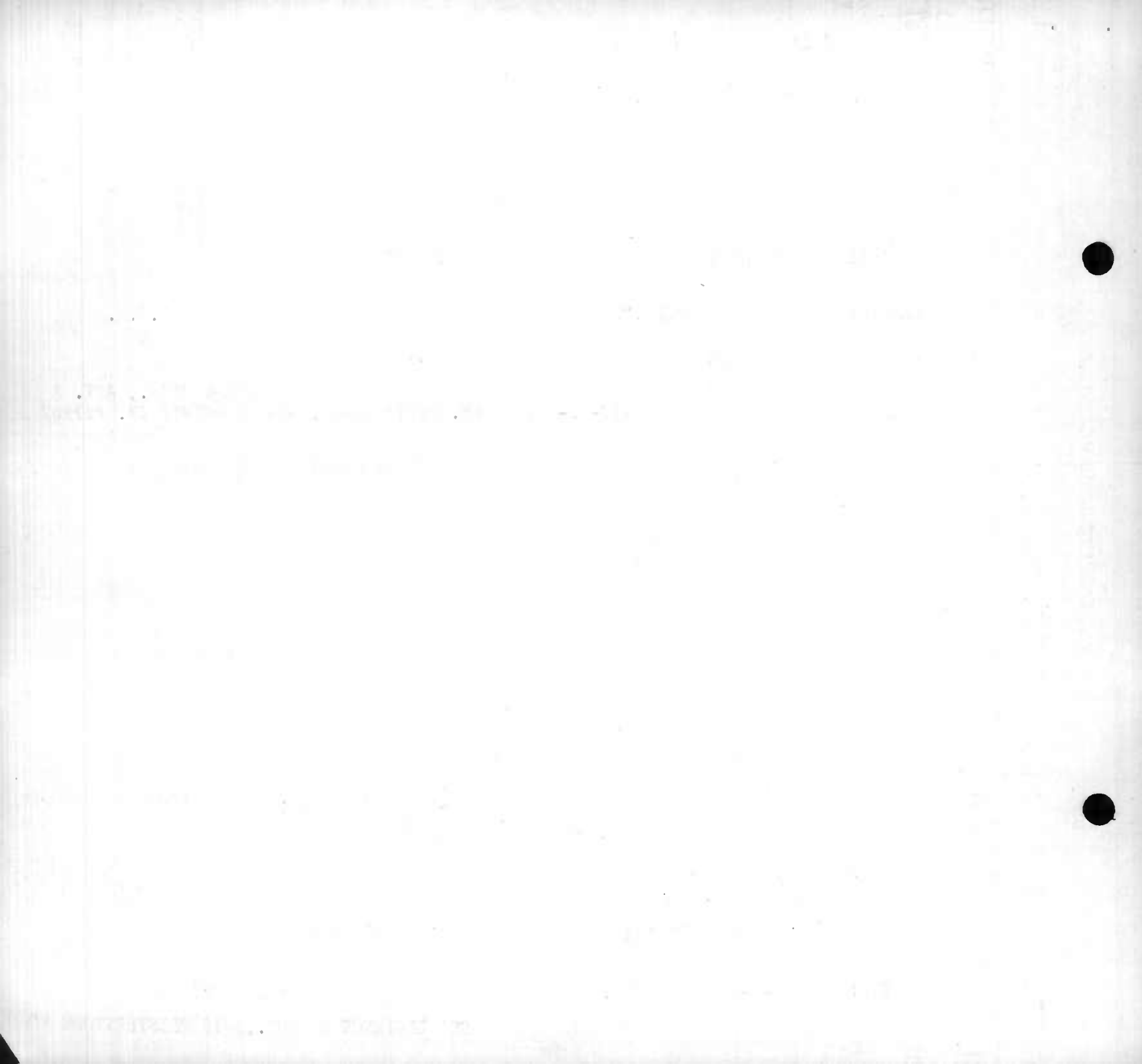
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. |
|---|-------------------------|--|--------------------------------------|--|
| 69 5773 | | 69 5773 | | |
| BIRTH NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) Elvira Pompei | | 2. DATE AND HOUR OF DEATH
June 4, 1969 11:30 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 | | A. STATE Maryland
B. COUNTY 1-02 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
509 S. Ellwood Avenue | | C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | E. STREET AND NUMBER
509 S. Ellwood Avenue | | |
| 5. SEX
Fem. | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/24/1900 | 9. AGE (in years last birthday)
69 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
home | | 11. BIRTHPLACE (State or foreign country)
Italy |
| 13. FATHER'S NAME
Angelo Pe ce | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO. | | 14. MOTHER'S MAIDEN NAME
unk. |
| | | 17. INFORMANT
Mr. Attilio Pompei | | |
| | | ADDRESS
509 S. Ellwood Avenue | | |
| 18. 151-9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE Carcinoma of Pancreas
DUE TO, OR AS A CONSEQUENCE OF:
(B) Carcinoma of Stomach
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
CANCER PANCREAS | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-25-69 19 to 6-4-69 19, that (I) (we) last saw the deceased alive on 6-4-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
John Constantini | | | | 23B. DATE SIGNED
6-6-69 |
| 23C. PHYSICIAN'S NAME (Type)
JOHN CONSTANTINI MD | | | | 23D. ADDRESS
234 S. CONKLING ST. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/10/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Redeemer |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fabel, M.D. | | 25C. FUNERAL DIRECTOR
Joseph N. Zannino |
| | | | | ADDRESS
263 S. Conkling Street. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

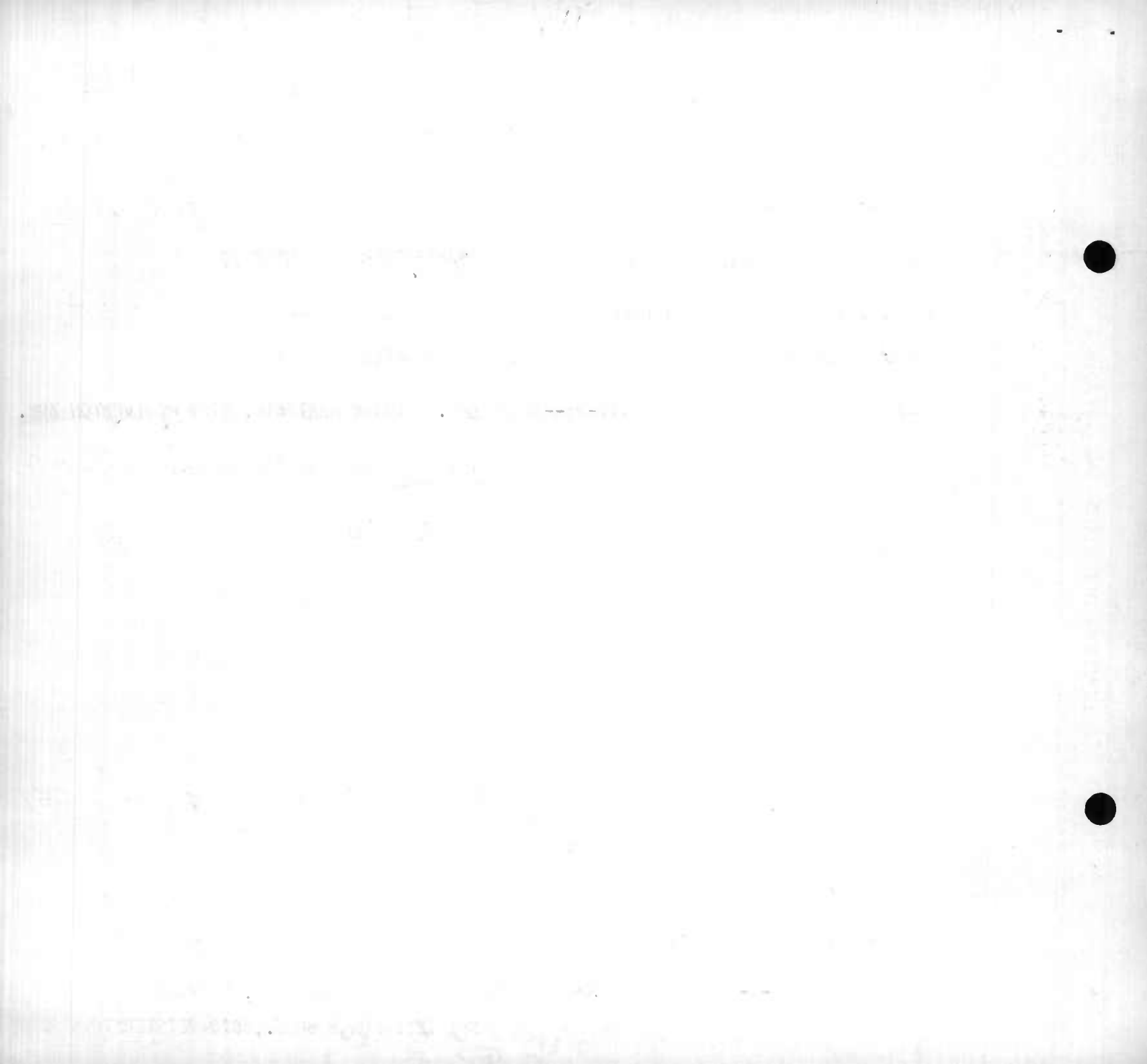
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | REG. NO. 69 5774 |
|--|-------------------------|---|---|--|---|---|
| <div style="display: flex; justify-content: space-between;"> G-330 69 5774 CERTIFICATE OF DEATH </div> | | | | | | |
| BIRTH NO. | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Samuel Gode</i> | | | 2. DATE AND HOUR OF DEATH
<i>6/4/69 3:45 P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Sinai Hospital</i> | | | A. STATE <i>Md</i> B. COUNTY <i>Balto</i> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | E. STREET AND NUMBER <i>8045 Woodgate Court</i> | | | |
| 5. SEX
<i>MALE</i> | 6. RACE
<i>WHITE</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>7/20/1929</i> | 9. AGE (in years last birthday)
<i>39</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>CASHIER</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>RACE TRACK</i> | | 11. BIRTH PLACE (State or foreign country)
<i>RUSSIA</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 13. FATHER'S NAME
<i>? GODEN</i> | | | |
| 14. MOTHER'S MAIDEN NAME
<i>UNKNOWN</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | | |
| 16. SOCIAL SECURITY NO.
<i>213-12-4617</i> | | | 17. INFORMANT
<i>MRS. YETTA GODET, 8045 WOODGATE CT. #21207</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>Myocardial Infarction 5 hours</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 years</i> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>ASCVD</i> | | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>June 4 1969</i> to <i>June 4 1969</i> , that (II) (we) last saw the deceased alive on <i>June 4 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | |
| 23A. SIGNATURE
<i>Robert Brull MD</i> | | | | | | 23B. DATE SIGNED
<i>June 4, 1969</i> |
| 23C. PHYSICIAN'S NAME (Type)
<i>ROBERT BRULL</i> | | | | | | 23D. ADDRESS
<i>SINAI HOSPITAL</i> |
| 24A. BURIAL CREMATION REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>6-5-69</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>BETH TFILOH</i> | | 24D. LOCATION (City, town, or county) (State)
<i>BALTIMORE, MARYLAND</i> |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 6 1969</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher, R.D.</i> | | 25C. FUNERAL DIRECTOR
<i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i> | | ADDRESS |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| C-500 69 5775 BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5775 | |
|--|---------------|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | COHN, FANNIE | | 6/4/69 5:05 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SINAI HOSPITAL | | | A. STATE md B. COUNTY Balt. | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN BALT. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER 5109 Woolverton Ave | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH XXXXX/88 | 9. AGE (In years lost birthday) XXX 77 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | AT HOME | | Austria USA | |
| 13. FATHER'S NAME ISRAEL REINES | | | 14. MOTHER'S MAIDEN NAME REBECCA ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 217-03-32340 | | MRS. PAULINE HARTFELD, 5109 WOOLVERTON AVE. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the Bladder - 3 months | | |
| ANTECEDENT CAUSES | | | (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD years | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/22 19 69 to 6/4 19 69, that (I) (we) last saw the deceased alive on 6/4 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| Paul D. Krieger | | | 6/4/69 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| PAUL D. Krieger | | | Sinai Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 6-5-69 | | HEBREW FRIENDSHIP | |
| | | | | BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUN 6 1969 | | J. E. Paul, Jr. | | SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |

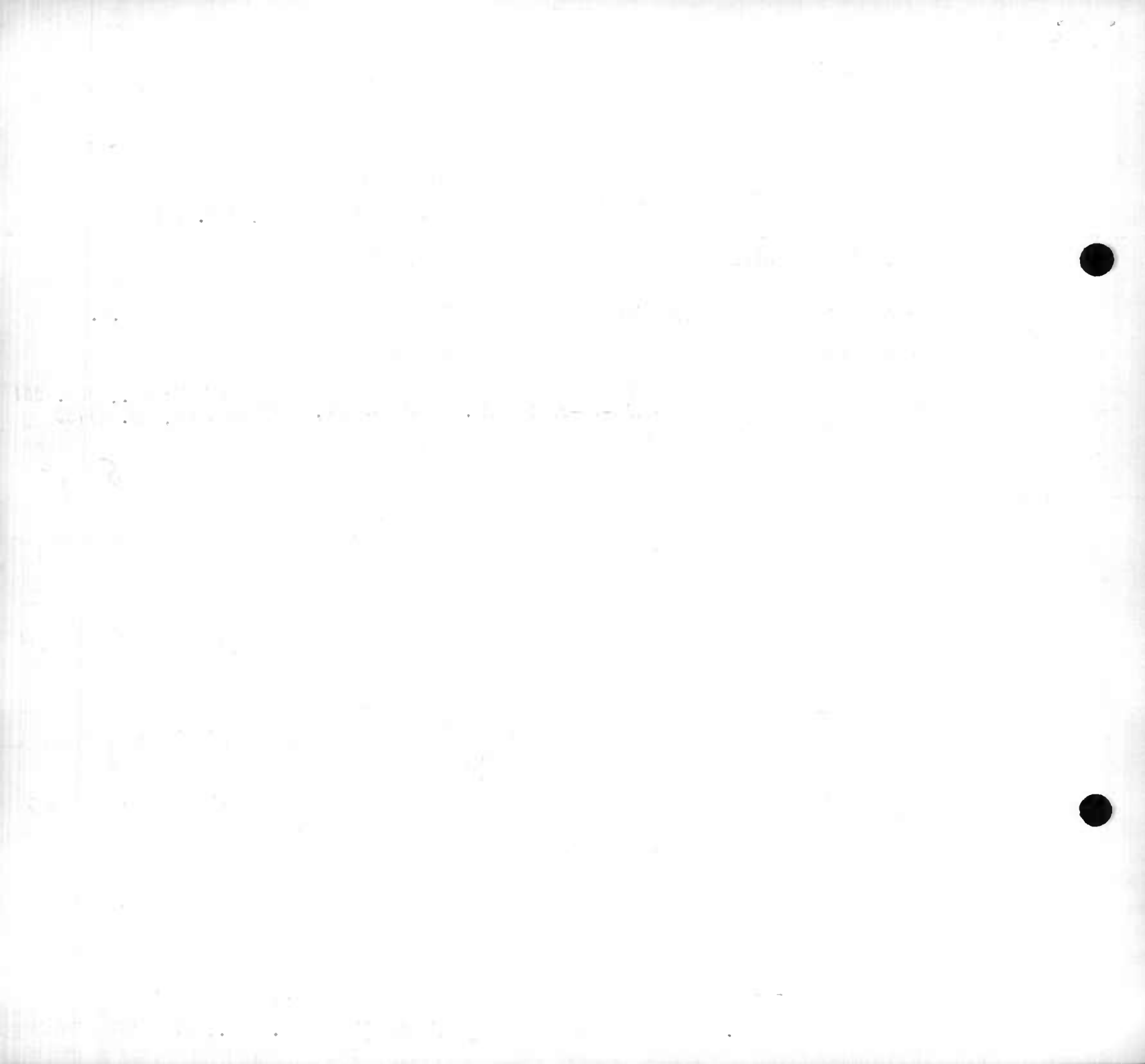


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 69 5776 | |
|--|-------------------------|---|--|---|--|--|--|
| BIRTH NO. <u>C-616</u> | | 69 5776 | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Rebecca Crawford</u> | | | | 2. DATE AND HOUR OF DEATH
<u>June 4, 1969 15:30 AM.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>42 Sinai Hospital of Baltimore</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> <u>53-00</u> | | | |
| | | | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<u>8607 GRAY FOX ROAD, APT. 201</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>XXXXXX</u> | 9. AGE (in years last birthday)
<u>84</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | | 11. BIRTHPLACE (State or foreign country)
<u>RUSSIA</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>DAVID LEVINE</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>DINA ETA ?</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>26-10-7507</u> | | 17. INFORMANT
<u>MRS. DORIS SHUGAR, RANDALLSTOWN, MD. 21133</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>ACUTE MYOCARDIAL INFARCTION</u> | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Acute Myocardial Infarction</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>8 days</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>BRONCHOPNEUMONIA</u> | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>Bronchopneumonia</u> | | <u>8 days</u> | |
| | | | | (C) <u>Fracture of Left Hip</u> | | <u>10 days</u> | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>II</u> | | | | | | | |
| 19A. DATE OF OPERATION
<u>5/25/69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>?</u> | | 20A. AUTOPSY? (Yes or No)
<u>?</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>Nursing home</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>Jewish Carelesscent Nursing Home</u> | | | |
| 21D. TIME OF INJURY (APPROX.)
<u>5/25/69 ?</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>Fall</u> | | | |
| 22. I certify that (this hospital) attended the deceased from <u>May 25</u> 19 <u>69</u> to <u>June 4</u> 19 <u>69</u> that (we) last saw the deceased alive on <u>June 4</u> 19 <u>69</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Joseph E. Mark MD</u> | | | | 23B. DATE SIGNED
<u>6/4/69</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Joseph E. Mark MD</u> | | 23D. ADDRESS
<u>Sinai Hospital of Baltimore</u> | | | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>6-5-69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>HEBREW YOUNG MEN</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTIMORE, MARYLAND 2</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 6 1969</u> | | 25B. NAME OF REGISTRAR
<u>David E. Bailey, R.D.</u> | | 25C. FUNERAL DIRECTOR
<u>SPL ZEINSON & BROS. INC., 6010 REISTERSTOWN RD</u> | | | |



1
S-360

69 5777

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5777

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY M. SUTER

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

6

4

69

6:35 a.m.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 4,

1969

6:35a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(If not in hospital or institution, give street address or location)
OR INSTITUTION

CERTIFICATE AMENDED

3-31-70

Sinai Hospital D.O.A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

15-38

6. SEX

Female

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

10. AGE (In years last birthday)

36

If Under 1 Yr. If Under 24 Hrs.

Months

Days

Hours

Min.

E. STREET AND NUMBER

3506 Fairview Rd.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

August J. Herrmann

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary Ganley

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.
218-28-5031

18. INFORMANT

ADDRESS

Mr. Edward Suter 3506 Fairview Road 21207

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Serax

(A) IMMEDIATE CAUSE ~~Serax~~ Ingestion
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3506 Fairview Rd.

22D. TIME
OF INJURY
(APPROX.)

6

4

69

?

m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject ingested overdose

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/4/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

June 7, 1969 Lake View Memorial Park

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Sykesville, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

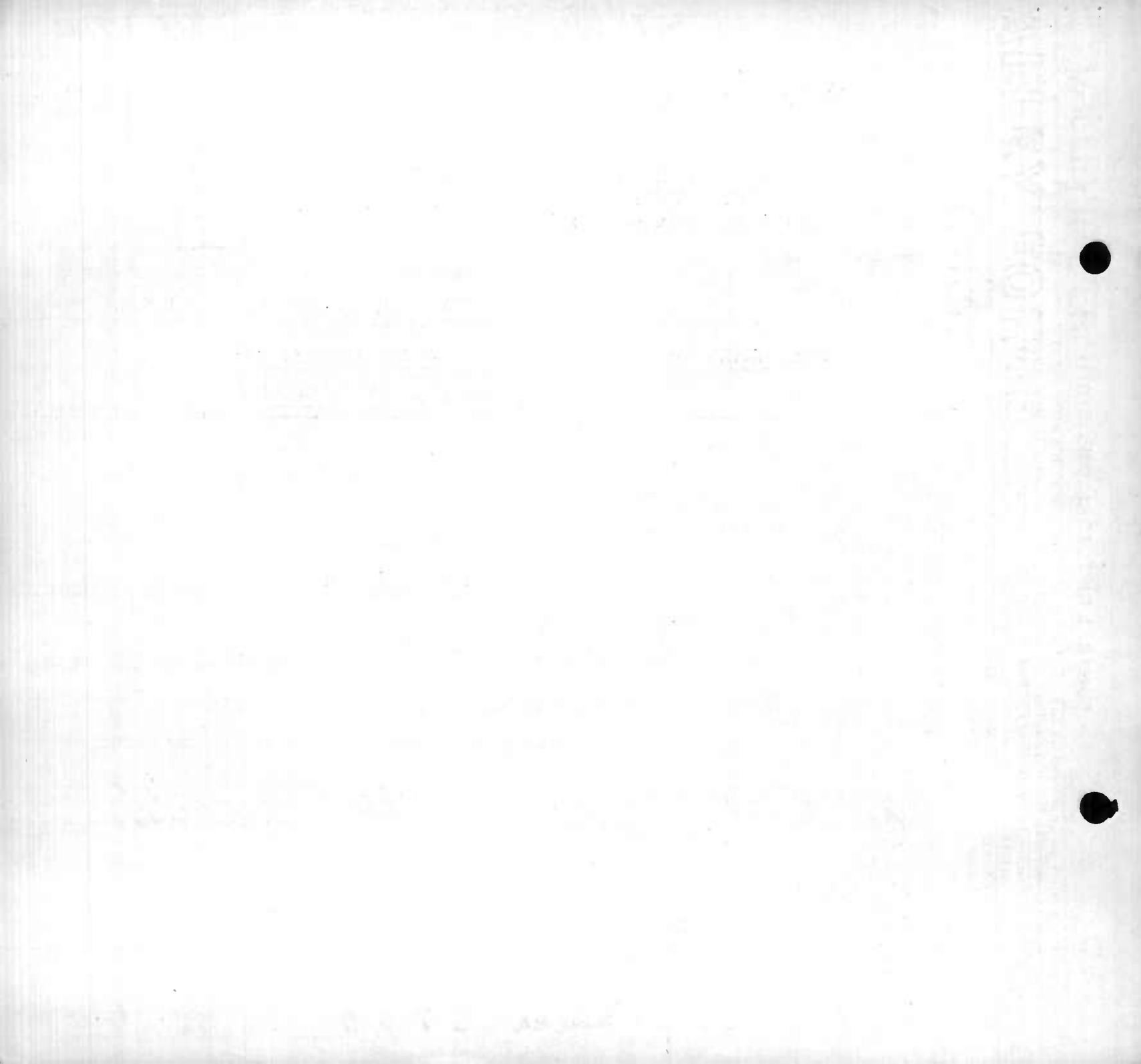
JUN 6 1969

Robert C. Taylor, M.D.

Loring Byers Chapel 8728 Liberty Road 21133

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased deceased prior to death; and (6) No physician who pronounced death was in regular attendance on the deceased prior to death; and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

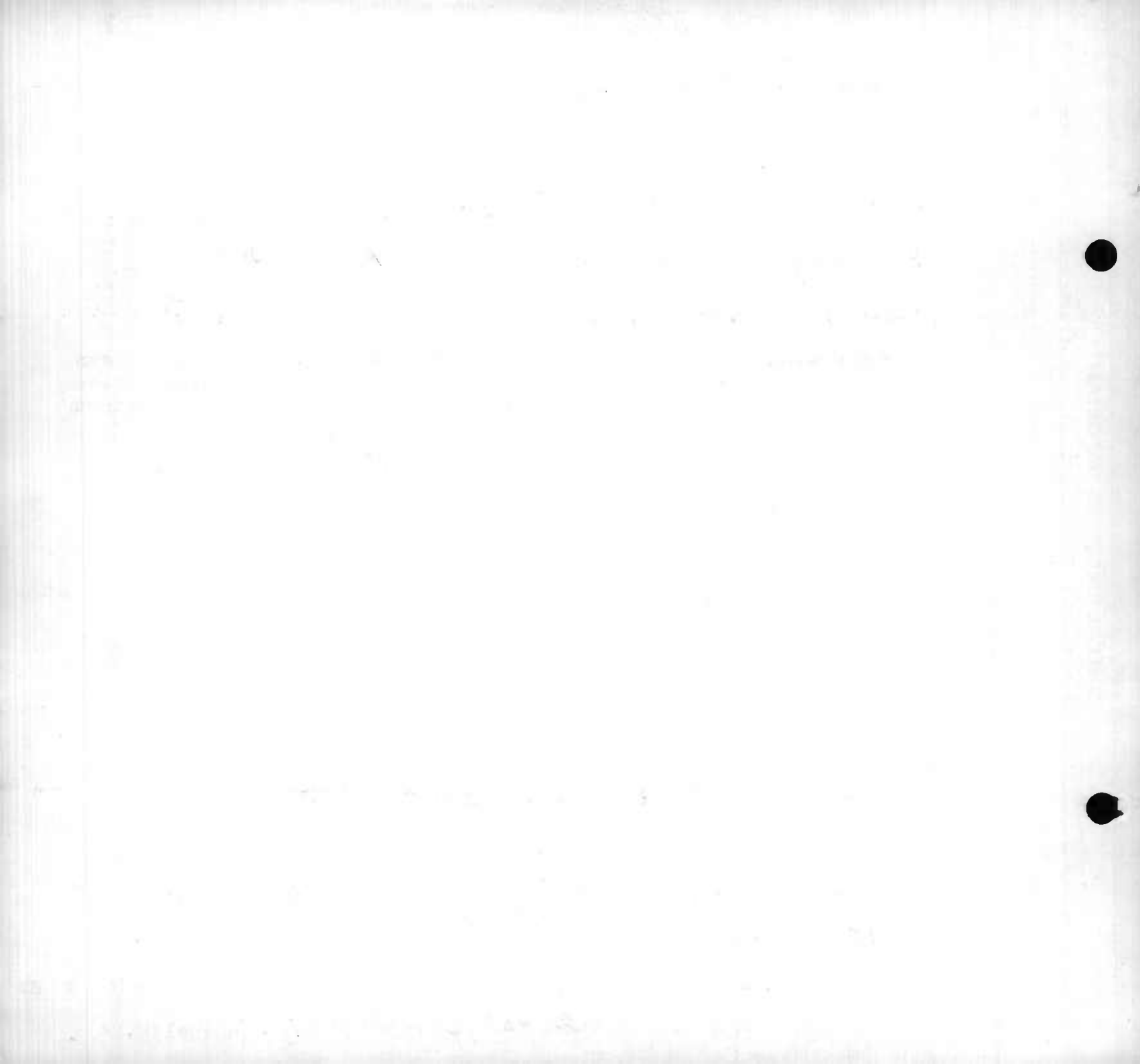
| | | | | | | | |
|---|--|---------|--|--|--|------------------|--|
| C-460 | | 69 5778 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5778 | |
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) E.
KATHERINE COLLIER | | | | 6-4-69 11:40 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE MARYLAND B. COUNTY 26-12 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND #21224 | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS?
BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 5-27-78 9. AGE (In years last birthday) 91 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 11. BIRTHPLACE (State or foreign country) MARYLAND, Baltimore | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY at home | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JOHN WHITE X McDorman | | | | 14. MOTHER'S MAIDEN NAME MATILDA McDORMAN WHITE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 216-56-7091 | | | | 17. INFORMANT ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224 | | | |
| 16. SOCIAL SECURITY NO. 216-56-7091 | | | | RECORDS# | | | |
| 18. 4-12-69 CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: CVA (C) ASCVD | | | |
| 19. DATE OF OPERATION 0 | | | | 20A. AUTOPSY? (Yes or No) No | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/20/69 19 to 6/4/69 19 that (I) (we) last saw the deceased alive on 6/4/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. Owen S. Surman | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Owen S. Surman | | | | 23D. ADDRESS 6118 E. Pratt St BALTO. MD. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 6/7/69 | | | |
| 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 6 1969 | | | | 25B. NAME OF REGISTRAR Walter E. Faber, M.D. | | | |
| 25C. FUNERAL DIRECTOR Schimminex Funeral Home, Inc. 3331 Brehms Lane | | | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------------|--|--|---|---|
| BIRTH NO. 69 5779 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 69 5779 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>ELIZABETH Laura Galloway</i> | | 2. DATE AND HOUR OF DEATH
<i>6-2-69 10:45 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>52-10</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Annapolis</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Lincoln Memorial Nursing Home</i> | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
<i>54 College Creek Terrace 21401</i> | |
| 5. SEX
<i>F</i> | 6. RACE
<i>Negro</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>1-30-97</i> | 9. AGE (In years last birthday)
<i>72</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Unknown Domestic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> |
| 13. FATHER'S NAME
<i>Frank NMH Smith</i> | | 14. MOTHER'S MAIDEN NAME
<i>Elizabeth NMH Brown</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | |
| 16. SOCIAL SECURITY NO.
<i>214-14-0033</i> | | 17. INFORMANT
<i>Margaret Lucille Pinkney Washington</i> | | 18. ADDRESS
<i>1231 Simms Place</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>436.9 I</i> | | CAUSE OF DEATH
<i>C. V. A</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5-22-69</i> to <i>6-2-69</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>6-2-69</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Hollis Seunarine</i> | | | | 23B. DATE SIGNED
<i>6-2-69</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Hollis Seunarine</i> | | 23D. ADDRESS
<i>2425 Entwistle Place</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | 24B. DATE
<i>6-6-69</i> | 24C. NAME OF CEMETERY or CREMATORY
<i>Annapolis Neck</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Anne Arundel Co MD</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 6 1969</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>PICKS! TONER</i> | |
| ADDRESS
<i>Annapolis, Md</i> | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

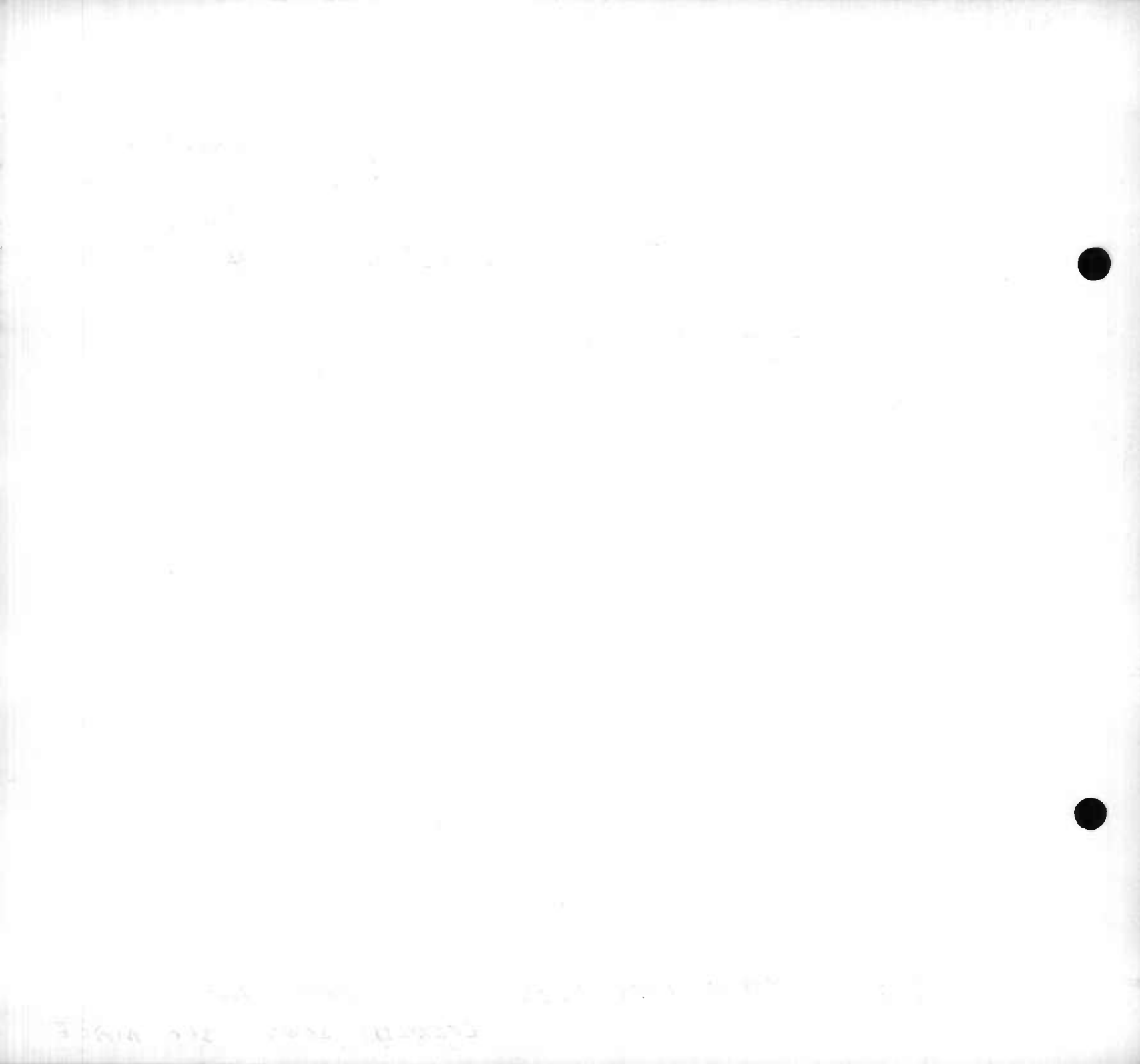
69 5780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 5780

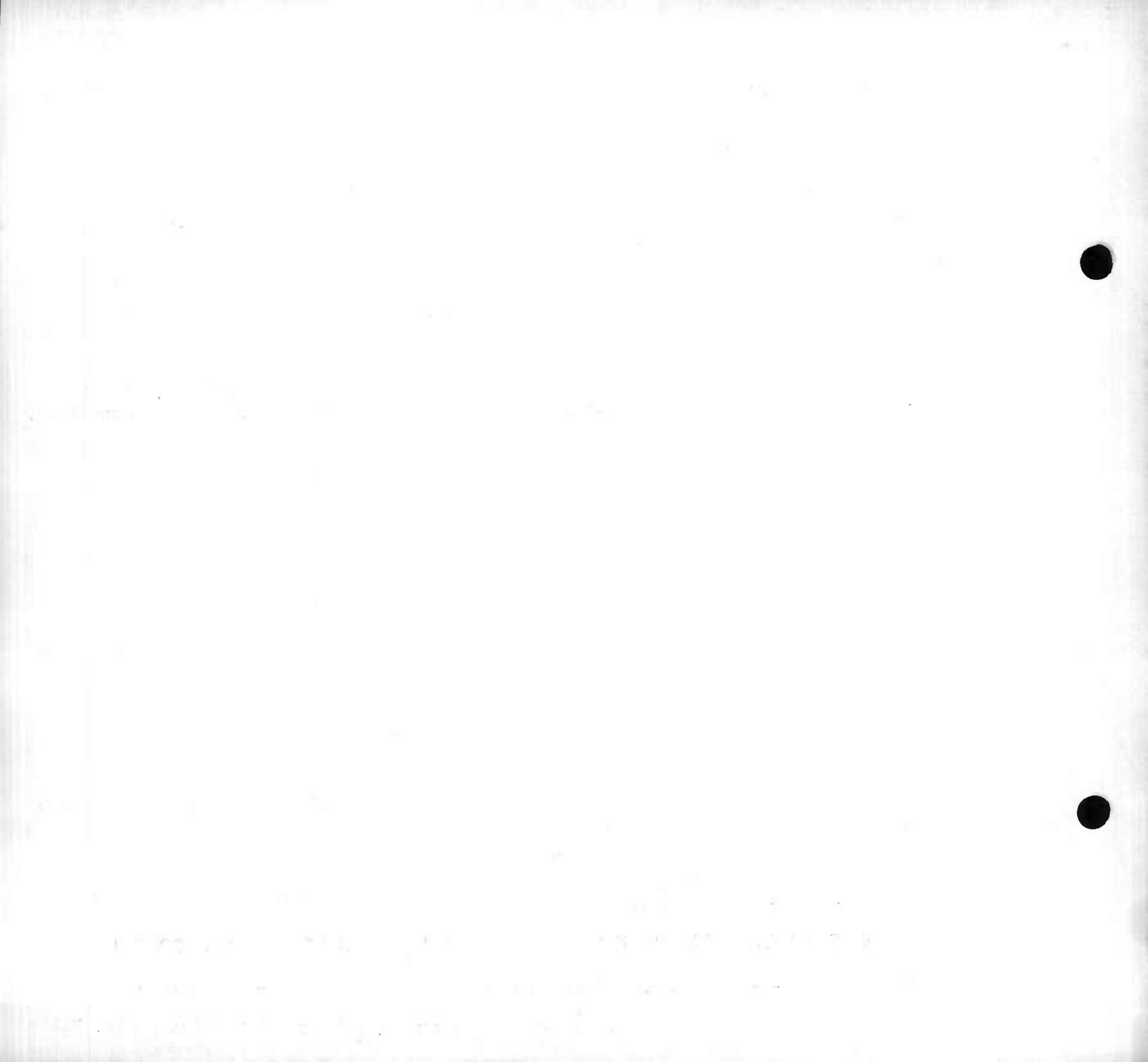
| | | | | | |
|--|----------------------------|--|-------------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Isabelle Solt</u> | | 2. DATE AND HOUR OF DEATH
<u>6/3/69</u> <u>1:10 a.m.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Maryland General Hospital</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <u>Maryland</u> B. COUNTY <u>BALTO.</u> | |
| | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>Box 360A Philadelphia Rd.</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12/22/03</u> | 9. AGE (In years last birthday)
<u>64</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>none</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | |
| 13. FATHER'S NAME
<u>HARRY MITCHELL</u>
<u>Not known</u> | | 14. MOTHER'S MAIDEN NAME
<u>Not known</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Medical chart (#319152)</u> | |
| 18. <u>436.9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>upper brain stem damage</u>
DUE TO, OR AS A CONSEQUENCE OF: <u>(probable)</u>
(B) <u>CVA.</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/19/1969</u> to <u>6/3/1969</u> that (I) (we) last saw the deceased alive on <u>6/3</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Ching-Hui Tsai, M.D.</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>6/3/69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Ching-Hui Tsai, M.D.</u> | | 23D. ADDRESS
<u>Maryland General Hospital.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 24B. DATE
<u>6/6/69</u> | 24C. NAME OF CEMETERY OR CREMATORY
<u>MORELANDS</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTO. MD.</u> | |
| 25A. DATE REC'D. BY HEALTH DEPT.
<u>JUN 6 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>CONTELY SONS</u> | |
| | | | | ADDRESS
<u>300 MACE</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 5781 | | BALTIMORE CITY HEALTH DEPARTMENT | | 69 5781 | |
|--|-------------------------|---|---|---|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) NELSON C. PAPE, SR. | | | 2. DATE AND HOUR OF DEATH
6-5-69 7 A. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
UNION MEMORIAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 27-11
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 4658 YORK ROAD | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-11-94 | 9. AGE (In years last birthday)
75 yr. | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
USA. | | 13. FATHER'S NAME
HENRY PAPE | | | |
| 14. MOTHER'S MAIDEN NAME
ELIZABETH CONRAD | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO. | | | |
| 16. SOCIAL SECURITY NO.
215-10-0445 | | 17. INFORMANT
chart William G. Pape 46 Carroll Rd. | | | |
| 18. 410.9 I CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
19A. DATE OF OPERATION 4-10-9 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? - | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) - | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | |
| 22. I certify that (1) (this hospital) attended the deceased from 6-3 19 69 to 6-5 19 69 that (H) (we) last saw the deceased alive on 6-5 19 69 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Stephen Goldberg | | | 23B. DATE SIGNED
6-5-69 | | 23C. PHYSICIAN'S NAME (Type)
DR STEPHEN GOLDBERGER |
| 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | |
| 24B. DATE
6-9-69 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
Robert E. Haller, M.D. | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard | |
| ADDRESS
4107 Wilkens Ave. 21229 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

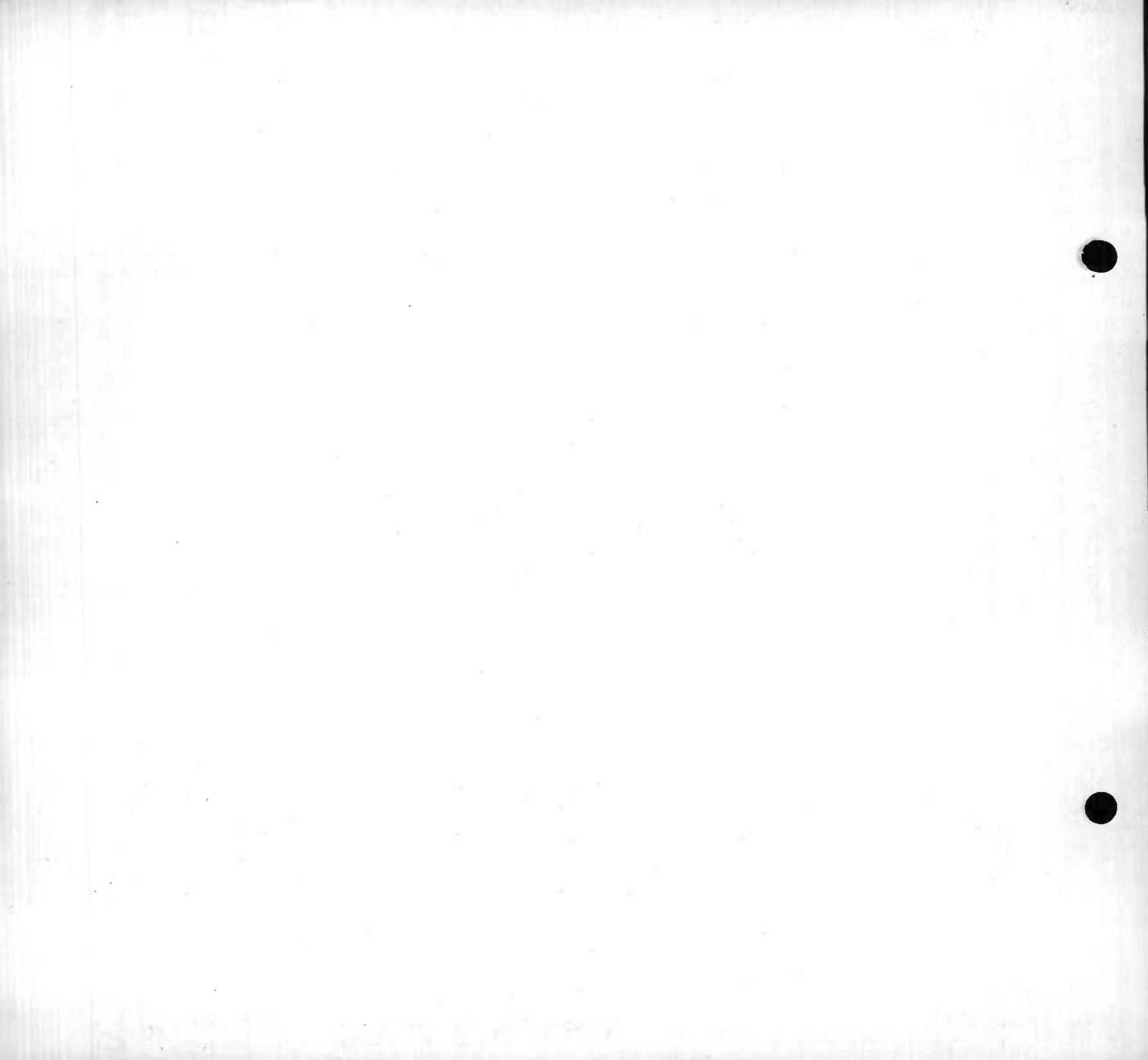
69 5782 CERTIFICATE OF DEATH

REG. NO. 69 5782

| | | | | | |
|---|------------------|---|-----------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Hazel Steen Franklin | | June 3, 1969 1:00 p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION

00 5304 Midwood Avenue
Baltimore, Md. 21212 | | | | A. STATE
Maryland 21212 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | B. COUNTY | |
| | | | | C. CITY OR TOWN
Baltimore | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
5304 Midwood Avenue | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/17/01 | 9. AGE (In years lost birthday)
67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY
-- | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Lawrence Steen | | 14. MOTHER'S MAIDEN NAME
Maude Hellman | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No -- | | 16. SOCIAL SECURITY NO.
217-05-3817 | | 17. INFORMANT
Thomas P McGrath 810 Chumleigh Rd. 21212 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF
Coronary Thrombosis
(B) DUE TO, OR AS A CONSEQUENCE OF:
Hypertensive Cardio-Vascular disease
(C) Diabetic - Complication of the Cardio | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
About every 2 months | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1954 to April 21, 1969, that (I) (we) last saw the deceased alive on May 19, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Manuel Sodaro | | | | 23B. DATE SIGNED
6/4/69 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Manuel Sodaro | | | | 23D. ADDRESS
4624 York Road 21212 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/6/1969 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | 24E. (City, town, or county) | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
Eugenia K. Seitz | | 25C. FUNERAL DIRECTOR
Seitz Funeral Home Balto. Md. 21212 | |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|
| 69 5783 CERTIFICATE OF DEATH | | | | | REG. NO. 69 5783 | | | | | |
| BIRTH NO. | | | | | 1. NAME OF DECEASED
(Type or Print) PRESTON, OSWALD WILLIAM | | | | | |
| 2. DATE AND HOUR OF DEATH
6/3/69 9:50 AM. | | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 19-02 | | | | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
67 Franklin Square Hospital | | | | | |
| C. CITY OR TOWN Baltimore. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | E. STREET AND NUMBER 4315 Gilmor St. | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/1/00 | | 9. AGE (In years last birthday) 69. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Maryland. | | 12. CITIZEN OF WHAT COUNTRY? America. | | | | |
| 13. FATHER'S NAME William J. Preston | | | | | 14. MOTHER'S MAIDEN NAME Catherine Caverey | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None. | | | | | 16. SOCIAL SECURITY NO. 216-32-5870 | | 17. INFORMANT HELEN M. PRESTON 4315 GILMOR ST. | | | |
| 18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | (A) IMMEDIATE CAUSE CVA, Pneumonia
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| 19A. DATE OF OPERATION 0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/12 19 68 to 6/3 19 69 that (I) (we) last saw the deceased alive on 6/3 19 69 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Swinder | | | | | 23B. DATE SIGNED 6/3/69 | | | 23C. PHYSICIAN'S NAME (Type) SWINDER | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE 6-6-69 | | 24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR WALTERS FUNERAL HOME PRATT-STRICKER | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5784

BIRTH NO. 48-23457

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
DANA FITZGERALD | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> 6 1 69
6:15 a. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Johns Hopkins Hospital D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 1, 1969 6:15 a. M. | |
| 6. SEX
Female | | 7. RACE
Colored | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
JAN 9 1969 | | 10. AGE (In years lost birthday)
5 | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 15. MOTHER'S MAIDEN NAME
Audrey Fitzgerald | | 18. INFORMANT
Audrey Fitzgerald | |
| 19. 746.7 | | ADDRESS
1415 Aisquith St. | |

| | | | | | |
|---|--|--|--|--|--|
| 19. 746.7 | | CAUSE OF DEATH
Endocardial Fibroelastosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
YES | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Edward F. Wilson | | M.D. | | DATE SIGNED
June 2, 1969 | |
| EXAMINER'S NAME (Type)
Edward F. Wilson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |

| | | | |
|---|--|---|---|
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
Jun 5, 1969 | 24C. NAME of CEMETERY or CREMATORY
Mt. Calvary Cem. | 24D. LOCATION (City, town, or county) (State)
Ann Arundel Co. Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | 25B. NAME OF REGISTRAR
James C. Taylor, M.D. | 25C. FUNERAL DIRECTOR
Joseph A. Locke Jr. | ADDRESS
1304 N. Central Ave. |

WALLEY

WALLEY

W. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5785 | |
|--|-------------------------|--|--|---|---|
| BIRTH NO. 69 5785 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Marion McC Feldmann</u> | | | 2. DATE AND HOUR OF DEATH
<u>5/31/69</u> <u>9</u> <u>8</u> <u>M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>Maryland General Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>116 University Parkway</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/17/99</u> | 9. AGE (In years lost birthday) <u>69</u> | If Under 1 Yr. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Wm. Mc Cormick</u> | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Brown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-24-7755</u> | 17. INFORMANT <u>Patient H.A. Feldmann</u> ADDRESS <u>116 Univ. Pkw.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>PULMONARY EMBOLI</u>
CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>Co. Lung</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>CARCINOMA of R LUNG</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) <u>—</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 Mo.</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>—</u> | | | | | |
| 19A. DATE OF OPERATION <u>5/12/69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Px of Ca</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u> | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>—</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/9</u> <u>1969</u> to <u>5/21</u> <u>1969</u> that (I) (we) last saw the deceased alive on <u>5/30</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>B. Ann Wood</u> | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>5/31/69</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. B. ANN WOOD</u> | | | 23D. ADDRESS <u>MD. GENERAL HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>6/3/69</u> | 24C. NAME of CEMETERY or CREMATORY <u>Lorraine</u> | | 24D. LOCATION (City, town, or county) (State) <u>Windsor Mill Rd. Woodlawn, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUN 6 1969</u> | | 25B. NAME OF REGISTRAR <u>Jacob E. Jacob, MD.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Mitchell Wiedefeld Home 6500 York Rd.</u> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5786

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES S KENT

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

5 31

69

8:35 a. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

3209 N. Charles St. D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

May 31,

1969

8:35 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

12-02

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1-20 1914

10. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3209 N. Charles St. Apt. 4-D

11. BIRTHPLACE (State or foreign country)

Minn.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Raymond A. Kent

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ph D

14B. KIND OF BUSINESS OR INDUSTRY

Music

15. MOTHER'S MAIDEN NAME

Frances Morey

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

WWII

17. SOCIAL
SECURITY NO.

276 20 1387

18. INFORMANT

ADDRESS

Roger Kent Pound Ridge, N.J.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty liver
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 31, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

6/2/69

24C. NAME OF CEMETERY or CREMATORY

Greenmount Crematory

24D. LOCATION (City, town, or county)

Greenmount Ave Balto.

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

JUN 6 1969

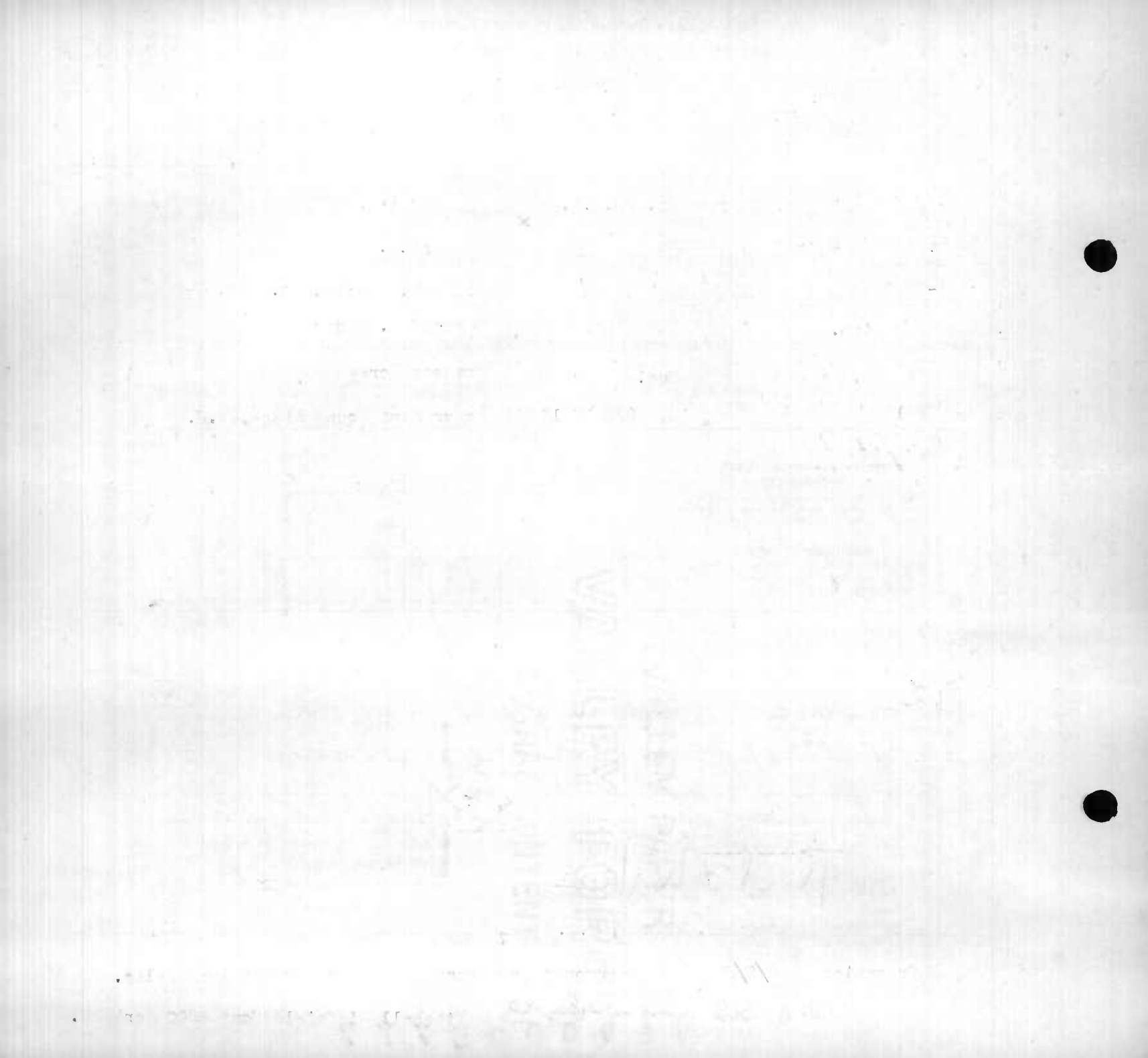
25B. NAME OF REGISTRAR

Edward E. Gaber, M.D.

25C. FUNERAL DIRECTOR

Mitchell Wisdefeld Home 6500 York Rd.

ADDRESS



4-500

69 5787

BALTIMORE CITY HEALTH DEPARTMENT

X

69 5787

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

| | | | |
|--|-------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print) JOHN L. HAWN | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 4, 1969 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
32 Mercy Hospital (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 4, 1969 8:16 P. | |
| 6. SEX
Male | 7. RACE
White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday)
55 | |
| 11. BIRTHPLACE (State or foreign country)
Fordwick, Va. | | 12. CITIZEN OF
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Director of Personnel | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO. | |
| 13. FATHER'S NAME
Russell J. Hawn | | 15. MOTHER'S MAIDEN NAME
Amelia Fick | |
| 18. INFORMANT
Virginia W. Hawn | | ADDRESS
206 Bristol Rd. Webster Groves Mo | |

| | | |
|--|--|--|
| 19. CAUSE OF DEATH
412.4 Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | |

| | | |
|--|---|--|
| 20A. DATE OF OPERATION
0 | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 21. AUTOPSY? (Yes or No)
No |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 22F. HOW DID INJURY OCCUR? |

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

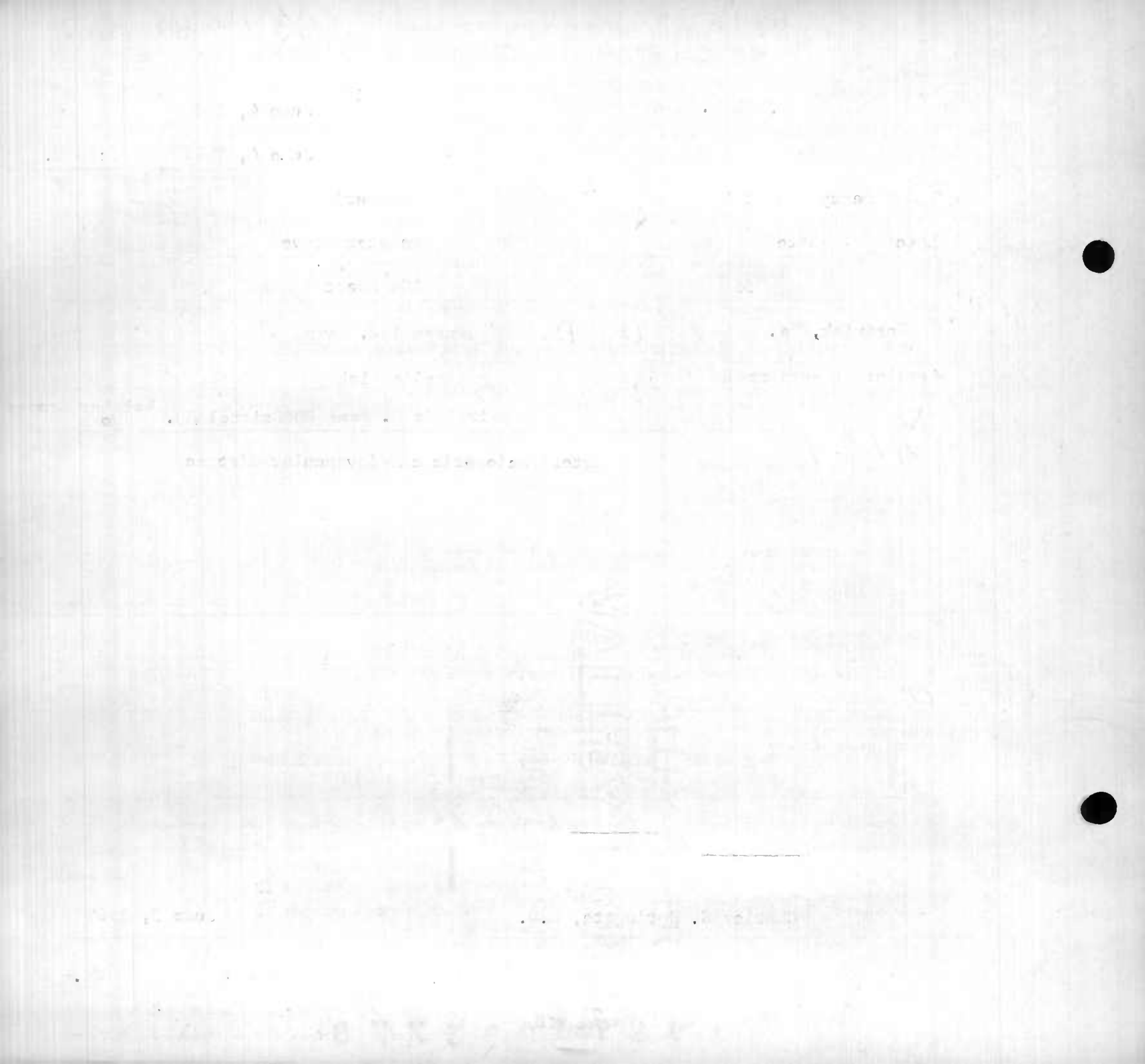
ACTUAL SIGNATURE *Charles S. Springate* M.D.
EXAMINER'S NAME (Type) **Charles S. Springate, M.D.**

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **June 5, 1969**

| | | | |
|--|--|---|---|
| 24A. BURIAL CREMATION, REMOVAL (Specify)
CREMATION | 24B. DATE
6/5/69 | 24C. NAME of CEMETERY or CREMATORY
GREENMOUNT CEM | 24D. LOCATION (City, town, or county) (State)
BALTO Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | 25B. NAME OF REGISTRAR
Robert E. Tabor | 25C. FUNERAL DIRECTOR
MITCHELL-WIEDEFELD | |

577 06500 YORK RD-12



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5788 |
|--|--|---|---|--|
| BIRTH NO. | | 69 5788 | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) <i>James R. Foster</i> | | 2. DATE AND HOUR OF DEATH
<i>6/3/69 2:30 A.M.</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>MD.</i> B. COUNTY <i>26-31</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>THE UNION MEMORIAL HOSPITAL</i>
<i>3200 CALVERT STS.</i>
<i>BALTO, 18, MD.</i> | | C. CITY OR TOWN
<i>BALTO.</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER
<i>4406 Bayonne Ave.</i> | | <i>21206</i> | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>10/29/94</i> | 9. AGE (In years lost birthday)
<i>74</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Adjuster</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Boaltnore & Ohio</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore Co. Maryland</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>Arthur Foster</i> | | |
| 14. MOTHER'S MAIDEN NAME
<i>Florence Taylor</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Yes W.W.I</i> | | |
| 16. SOCIAL SECURITY NO.
<i>705-03-9088</i> | | 17. INFORMANT
<i>Mrs Ellen M. Foster</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>Pneumonia</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>5 weeks</i> | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES | | (B) <i>Urinary tract infection</i> | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) <i>6 weeks</i> | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
<i>No</i> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>6/2</i> <i>6/3</i> <i>19 69</i> to <i>6/3</i> <i>19 69</i> , that (I) was last saw the deceased alive on <i>6/2</i> <i>19 69</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<i>James R. Foster</i> | | 23B. DATE SIGNED
<i>6/3/69</i> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)
<i>E. H. RIBEIRO, M.D.</i> | | 23D. ADDRESS
<i>THE UNION MEMORIAL HOSPITAL</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | 24B. DATE
<i>6-6-1969</i> | 24C. NAME OF CEMETERY or CREMATORY
<i>Moreland Park</i> | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 6 1969</i> | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, MD.</i> | 25C. FUNERAL DIRECTOR
<i>Lassahn Funeral Home 7401 Belair Road 21236</i> | | |

14-00000-177



THE UNIVERSITY OF CHICAGO

LIBRARY

1
P-656

69 5789 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5789
REG. NO.

BIRTH NO.

| | | | |
|---|-------------------------|--|--|
| 1. NAME OF DECEASED
(Type or Print)
OLGA ENRIQUETA PRIMARD | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input checked="" type="checkbox"/> Month Day Year
June 2, 1969 7:35 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
4158 Falls Road | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 2, 1969 7:35 P.M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland | | B. COUNTY
13-48 | |
| 6. SEX
female | 7. RACE
white | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH
2-11-14 | | 10. AGE (In years lost birthday)
55 | |
| 11. BIRTHPLACE (State or foreign country)
Santiago, Chile | | 12. CITIZEN OF WHAT COUNTRY?
Chile | |
| 13. FATHER'S NAME
Nicolas Primard | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Seamstress | |
| 15. MOTHER'S MAIDEN NAME
Maria Ledoit | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 17. SOCIAL SECURITY NO.
212-56-5083 | | 18. INFORMANT
Maria Anglies Taylor | |
| 19. CAUSE OF DEATH
Overdose of Barbiturates | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Overdose of Barbiturates | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
Yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
<input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
home | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
4158 Falls Road 13-48 | |
| 22D. TIME OF INJURY (APPROX.)
6/2/69 7:35 P.M. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR?
Ingested an overdose of drugs | | 23. | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
6-5-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Greenmount Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
William E. Johnson | |
| 25C. FUNERAL DIRECTOR
William E. Johnson | | 25D. ADDRESS
8521 Loch Raven Bl Baltimore, Md | |

WALLING POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| F-652 | | 69 5790 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5790 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) FRINGER GLADYS | | | | 2. DATE AND HOUR OF DEATH
6.3.69. 11.00 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
BALTIMORE CITY HOSPITALS D2
4940 EASTERN AVE. 21224 | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
10.10.13 | | 9. AGE (in years last birthday) 55 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
EDISON BUNTING | | | | 14. MOTHER'S MAIDEN NAME
BARBARA MUELLER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
217-20-3441 | | 17. INFORMANT
BCH RECORDS: 4940 EASTERN AVE. 21224 | |
| 18. CAUSE OF DEATH
4121 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHOPNEUMONIA
(B) OLD CEREBRAL THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF:
(C) HYPERTENSIVE ARTERIOSCLEROTIC HEART DK.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-4 19 68 to 6-3 19 69 that (I) (we) last saw the deceased alive on 6-3 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Abraham Garcia MD. | | | | 23B. DATE SIGNED
6.3.69. | | | |
| 23C. PHYSICIAN'S NAME (Type)
ABRAHAM GARCIA MD. | | | | 23D. ADDRESS
BALTIMORE CITY HOSPITALS
4940 EASTERN AVE. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/6/69 | | 24C. NAME of CEMETERY or CREMATORY
Linden Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
1107 N. 130 E. Fort Ave. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 69 5791 | |
|---|--|---|--|---|--|--|--|
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Charles H. Little Jr.</u> | | | | 6/14/69 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>48 Maryland General Hospital</u> | | | | A. STATE <u>Pa.</u> B. COUNTY <u>YORK</u> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
<u>Hanover</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
<u>6/12/12</u> | | 9. AGE (In years lost birthday) <u>56</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Lift Operator</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Box Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Pa.</u> | |
| 13. FATHER'S NAME
<u>Charles T. Little</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Yohe</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes WWII Jul 13, 1943 Dec 30, 1944</u> | | | | 16. SOCIAL SECURITY NO.
<u>176-05-1917</u> | | 17. INFORMANT
<u>Patient.</u> | |
| 18. <u>150X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>Septic Shock</u> | | <u>12 hrs.</u> | |
| ANTECEDENT CAUSES | | | | (B) <u>Emphysema (R)</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) <u>Adenocarcinoma Esophagus</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
<u>3/14/69</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Esophagus</u> | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> 19 <u>69</u> to <u>6/14</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/14</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>B. Ann Wynn M.D.</u> | | | | 23B. DATE SIGNED
<u>6/14/69</u> | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS | | | | 23E. DEGREE | | 23F. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>June 7, 1969</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>ST. MARYS ANNUNCIATION</u> | | 24D. LOCATION (City, town, or county) (State)
<u>McSherrystown ADAMS PA.</u> | |
| 25A. DATE REC'D BY
<u>JUN 6 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>B. P. Gipe & Sons</u> | | ADDRESS
<u>Reisterstown, Md.</u> | |



B-400

69 5792

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5792

| | | | | | |
|--|--------------------|--|--|---|------------------------------|
| BIRTH NO. 690898 | | 1. NAME OF DECEASED
(Type or Print)
JOHN A. BAILEY | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
6 2 69 2:03 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
ADDRESS OR LOCATION
716 E. 43rd Street | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 2, 1969 2:03 a.m. | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 27-10 | |
| 6. SEX
Male | 7. RACE
Colored | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
1-19-69 | | 10. AGE (In years lost birthday)
4 | 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY? |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME
MARY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT
JOHN BAILEY 716 E 43rd St. | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
DISEASE OR CONDITION
Sudden death in infancy
(Interstitial pneumonia)
DUE TO, OR AS A CONSEQUENCE OF:
DUE TO, OR AS A CONSEQUENCE OF:
DUE TO, OR AS A CONSEQUENCE OF:
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
YES | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE: [Signature] M.D.
EXAMINER'S NAME (Type): Edward F. Wilson, M.D.
DATE SIGNED: June 2, 1969 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-5-69 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
[Signature] | | 25C. FUNERAL DIRECTOR
Wm C March | |
| | | | | 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | |
| | | | | ADDRESS
928 E NORTH | |

7. 1947

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69 5793

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Eileen Marie Boswell

2. DATE OF DEATH

May 29, 1969

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4516 North Charles Street
Apartment F
Baltimore, Maryland 21210

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 21210

D. STREET ADDRESS

(If rural, give location)

4516 N. Charles Street Apt. F

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

4/21/1898

9. AGE (In years last birthday)

71

If Under 1 Yr. Months

If Under 24 Hrs. Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Vise Pres. -retired

10B. KIND OF BUSINESS OR INDUSTRY

Oles Envelope

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Kirby

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215-03-8526

17. INFORMANT

ADDRESS

Margaret Seitz 5627 Frankford Ave

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, or any, giving rise to the above cause (not stating underlying condition directly leading to death)

(A) DUE TO

Myocardial Infarction

instantaneous

(B) DUE TO

Hypertensive Arteriosclerotic Cardiovascular Disease

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Emphysema, Asthmatic Bronchitis

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/13 1967 to 11/20/68

and that in (my) (our) opinion death occurred at 1:29/69 11/20/68 5:25 PM 1969

and that in (my) (our) opinion death occurred at 1:29/69 11/20/68 5:25 PM 1969

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS. ☒MED. DIRECTOR ☐STAFF PHYS. ☐

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/2/69.

24C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

VS 150

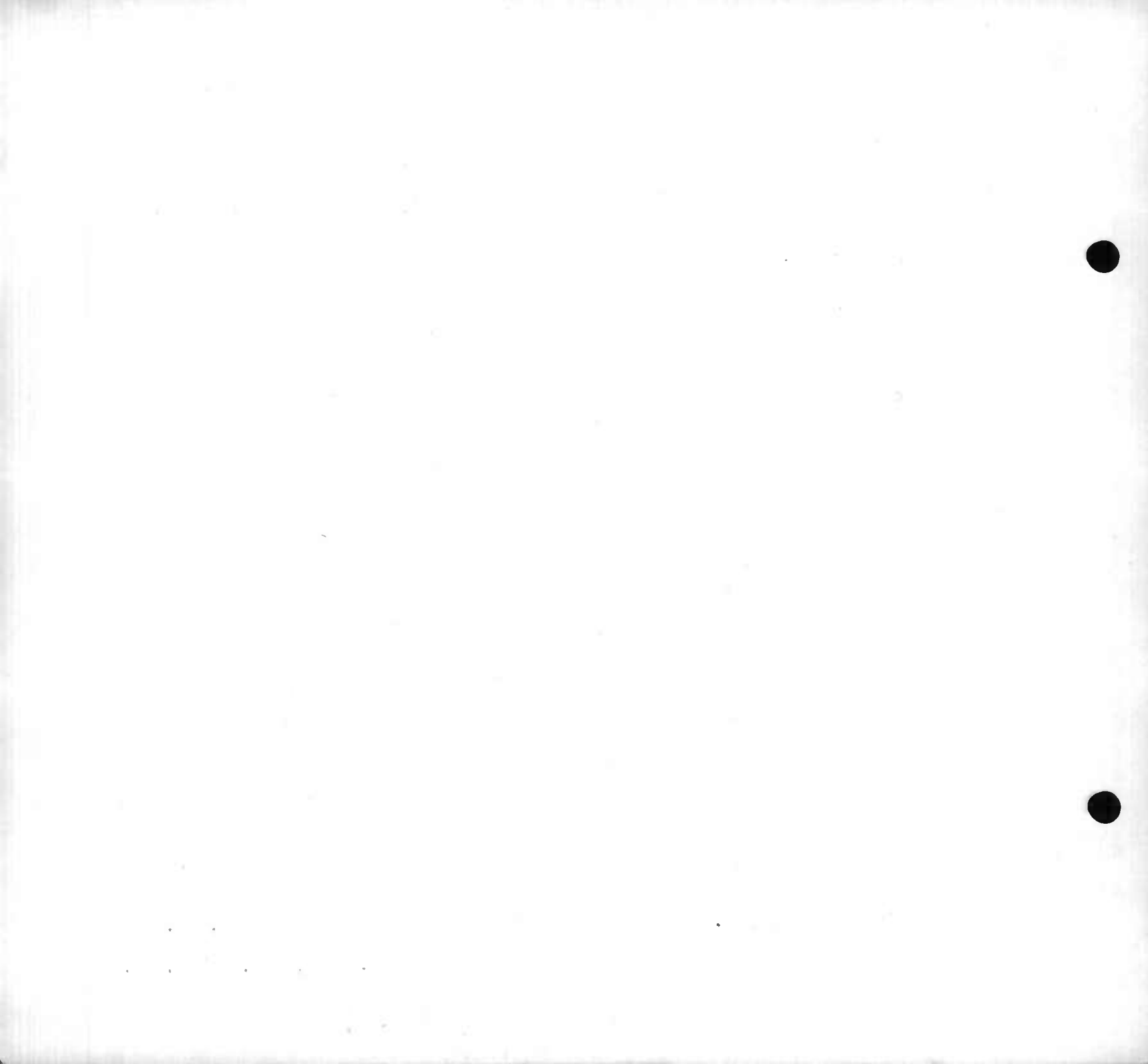
JUN 6 1969

Robert E. Fisher, M.D.

Leonard J. Ruck, Inc. Balto. Md. 21214

19690005784

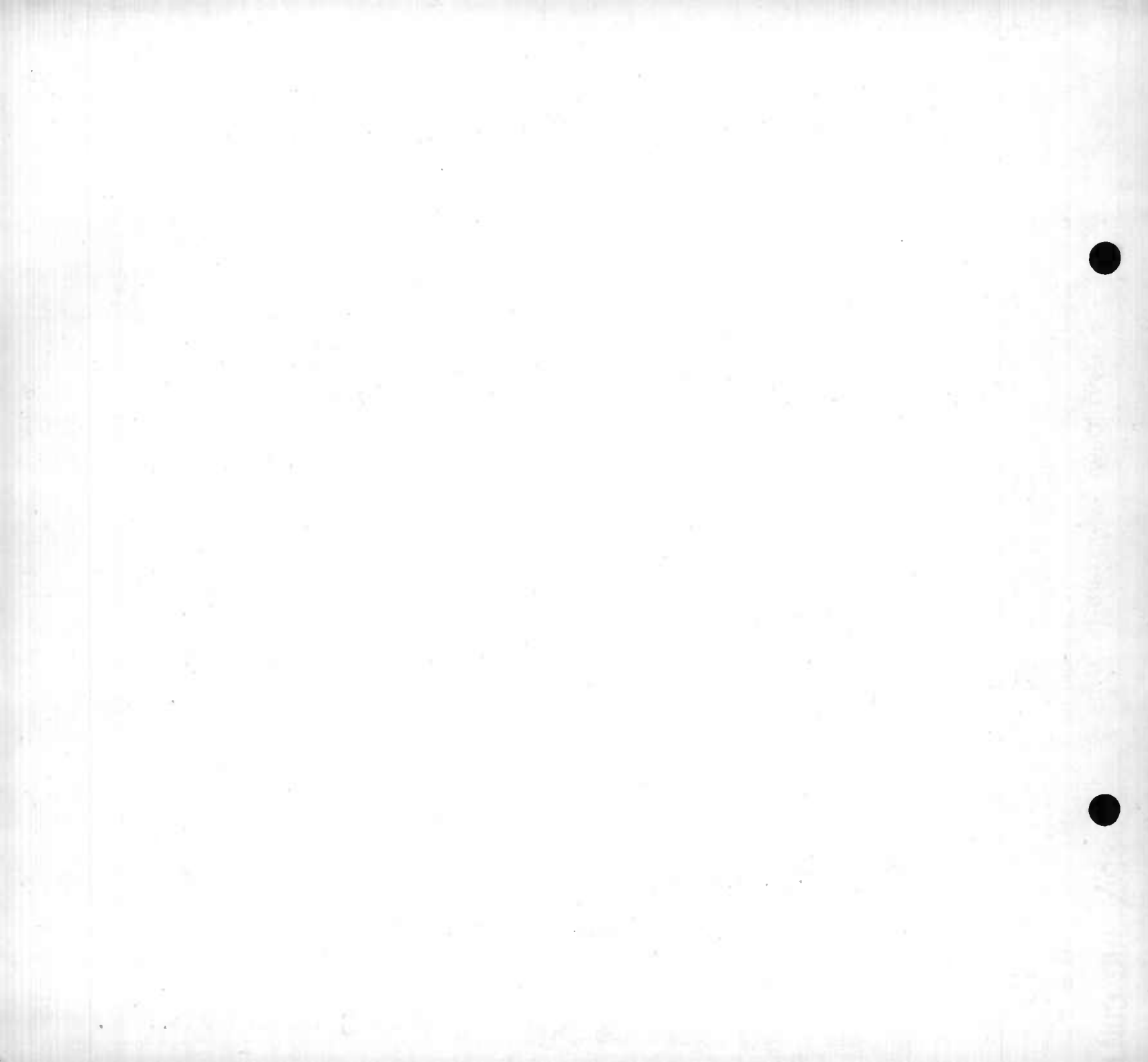
THIS IS A PERMANENT RECORD.
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|---------------------|---|------------------------------------|---|---|
| 69 5794 | | CERTIFICATE OF DEATH | | 69 5794 | |
| 1. NAME OF DECEASED
(Type or Print) Rosi, Noto | | 2. DATE AND HOUR OF DEATH
June 4-69. 11.30P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
BON SECOURS Hosp. 4th | | 4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission)
A. STATE BALTIMORE B. COUNTY BALTO. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 2025 W. Fayette St | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
3634 Valley Terrace Apt. 4 | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-24-92 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Italy | |
| 12. CITIZEN OF WHAT COUNTRY?
Italy | | | | | |
| 13. FATHER'S NAME
Joseph Ciagugeni | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-03-0068 | | 17. INFORMANT
Vincent J. Noto | |
| | | ADDRESS
4765 Bonnie Brae Rd 21208 | | | |
| 18. 41019 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ACUTE MYOCARDIAL INFARCT | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
ARTERIOSCLEROTIC HEART DISEASE | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF:
YEARS | | | |
| (C)..... | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-4-69 to 6-4-69 , that (I) (we) last saw the deceased alive on 6-4-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Agustín del Campo MD | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
6-4-1969 | |
| 23C. PHYSICIAN'S NAME (Type)
AGUSTIN del CAMPO MD | | 23D. ADDRESS
BON SECOURS Hosp Balto. Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-9-69 | | 24C. NAME of CEMETERY or CREMATORY
New Cathedral | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | 25B. NAME OF REGISTRAR
Robert E. Talbot, MD | | 25C. FUNERAL DIRECTOR
Leonard J. Buck Inc Balto., Md. | |
| ADDRESS
4765 Bonnie Brae Rd 21208 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

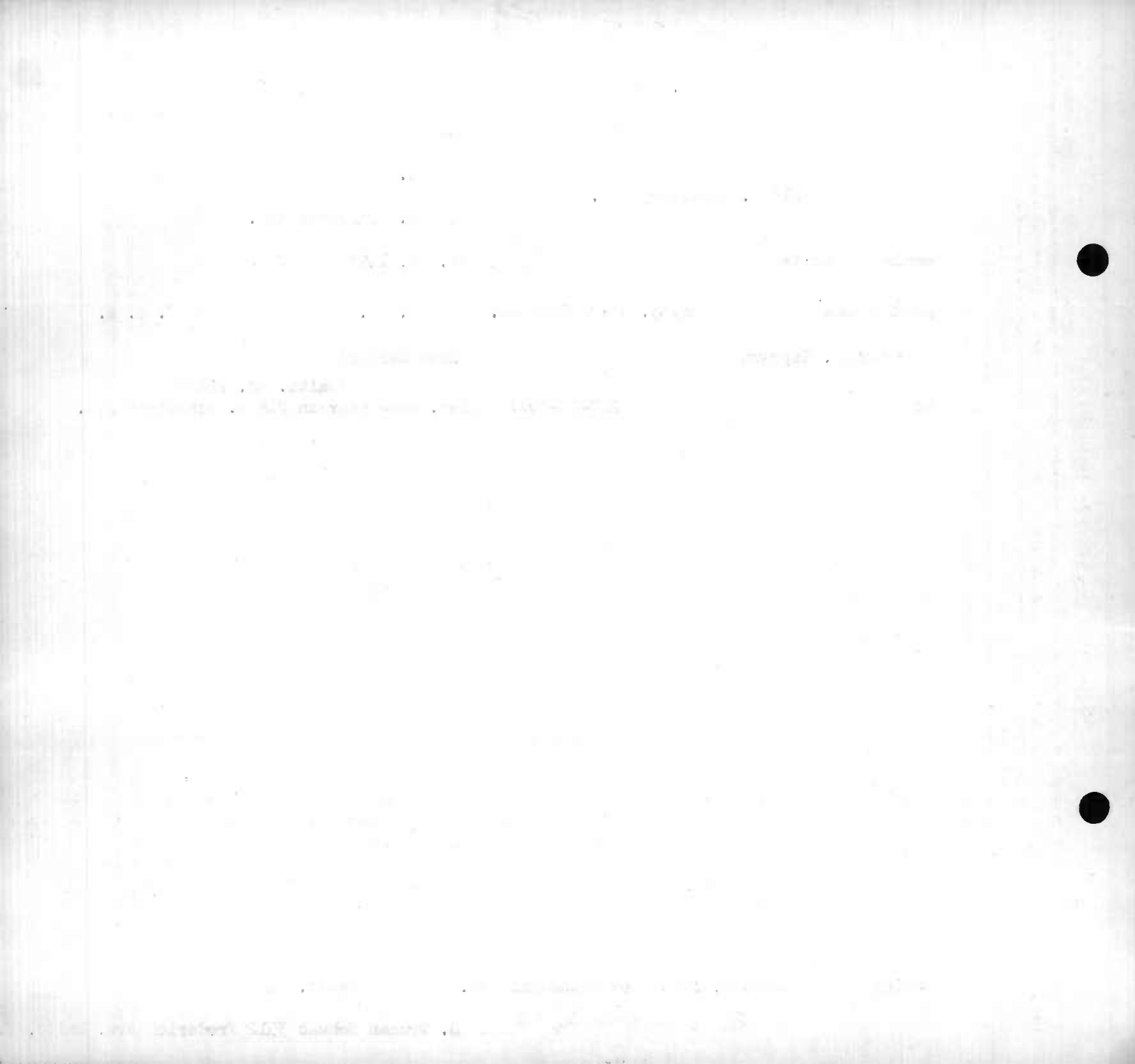
REG. NO. 69 5795

| | | | | | |
|--|------------------|---|--|---|---------------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Helen A. Kapraun | | June 3, 1969 545A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

218 S. Monastery Ave. | | | | A. STATE
Maryland | |
| | | | | B. COUNTY | |
| | | | | C. CITY OR TOWN
Balto. | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
218 S. Monastery Ave. | |
| | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Oct. 31, 1894 | 9. AGE (In years last birthday)
74 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Book Binder | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. Sales Book Co. | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | |
| 13. FATHER'S NAME
Frank J. Kapraun | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
217-56-7977 | |
| 17. INFORMANT
Miss. Rose Kapraun | | | | ADDRESS
Balto. Md. 21229
218 S. Monastery Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Recurrent Carcinoma of Left Breast & Glands
Metastasis
(B) DUE TO, OR AS A CONSEQUENCE OF:
Carcinoma of Left Breast &
(C) Removal

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
March 1966
April 1960 | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1969 to 6/3/69, that (I) (we) last saw the deceased alive on 6/2/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Eliot W. Johnson | | | | 23B. DATE SIGNED
6/3/69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
3432 Frederick Ave.
Baltimore Md 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
June 6, 1969 | | 24C. NAME of CEMETERY or CREMATORY
New Cathedral Cem. | |
| 24D. LOCATION
Balto. Md | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 6 1969 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Gabe, M.D. | | 25C. FUNERAL DIRECTOR
G. Truman Schwab | | | |
| ADDRESS
3512 Frederick Ave. Balto. Md | | | | | |



1
W-452

69 5796 BALTIMORE CITY HEALTH DEPARTMENT

69 5796

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)E.
CARROLL WILLIAMS2. DATE
OF
DEATHKnown ☒
Estimated ☐Month
JuneDay
5, 1969

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital (DOA)

3. DATE
PRONOUNCED DEADMonth
JuneDay
5, 1969

Year

Hour

10:30 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

16-08

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

May 3, 1942

10. AGE (In years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

612 Allendale Street (29)

11. BIRTH PLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James A. Williams

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemp.

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Louanna Backusville

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Louanna Williams 612 Allendale

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cerebro-cranial injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
house22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3rd flr. of 2738 Pennsylvania Ave. 15-04

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 6-5-69 ? m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Jumped from 3rd floor window

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 5, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

June 9, 1969

24C. NAME of CEMETERY or CREMATORY

Bald Natl Cem.

24D. LOCATION (City, town, or county) (State)

5501 Fredrick Ave.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

June 6 1969 Robert E. Faber, M.D.

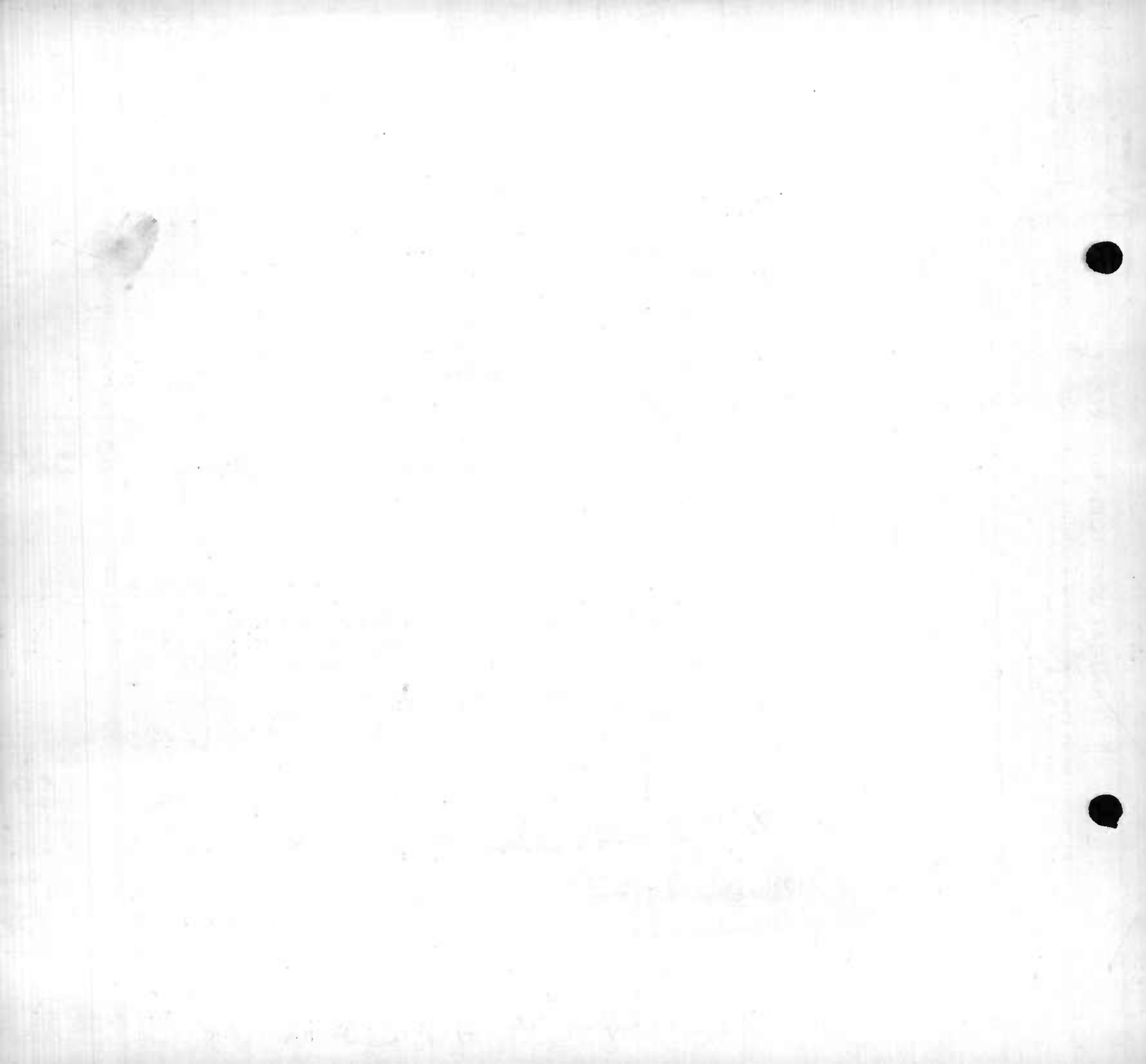
25C. FUNERAL DIRECTOR

Zeph E. Luckman 112977 Cashin

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5797 | |
|--|--|--|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) JAMES A. SOMERS | | 2. DATE AND HOUR OF DEATH
6-6-69 7 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY 20-04 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
D.O.A. At Bon Secure Hosp. BALTO., MD. | | | C. CITY OR TOWN
BALTO. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX M. 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
1900 | | 9. AGE (In years lost birthday) 69 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE. | | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Albert Somers. | | | 14. MOTHER'S MAIDEN NAME
PANSONS. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
NONE. | | 17. INFORMANT
Joseph Earl Somers. |
| 18. 410.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Thrombosis Coronary Acute | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | (B) _____
(C) _____ | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1 19 60 to June 6 19 69 , that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
C. J. Mandelaris M.D. | | | | 23B. DATE SIGNED
6-6-69 | |
| 23C. PHYSICIAN NAME (If not 2308 Edmondson Ave.)
Baltimore, Md. | | | | 23D. ADDRESS
2308 Edmondson Ave. BALTO. MD. | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
BURIAL | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Joseph E. Gable, M.D. | | 25C. FUNERAL DIRECTOR
George H. Schwab Inc. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5798 | |
|--|------------------|---|----------------------------|---|---|
| BIRTH NO. 69-10626 | | 69 5798 | | BALTIMORE CITY HEALTH DEPARTMENT | |
| 1. NAME OF DECEASED
(Type or Print) SEIDEL BABY GIRL | | 2. DATE AND HOUR OF DEATH
6-2-69 12:15 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
35 CHURCH HOME AND HOSPITAL | | A. STATE
MARYLAND | | B. COUNTY
2120927-65 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTO. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
1301 W. COLD SPRING LAKE | | | |
| 5. SEX
FE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-1-69 | 9. AGE (In years last birthday)
3 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
N.B. | | 10B. KIND OF BUSINESS OR INDUSTRY
N.B. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
JACOB A. SEIDEL | | | |
| 14. MOTHER'S MAIDEN NAME
JESSICA ELAINE TAYLOR | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
(CHART) | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
7690 I | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Due to, or as a consequence of: Creation of heart beat app 3 hr. | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Incompetent cardiac and
Due to, or as a consequence of:
(C) Prematurity | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. Sylvan Frieman, M.D. | | 23B. DATE SIGNED
6-3-69 | | 23C. PHYSICIAN'S NAME (Type)
Dr. Sylvan Frieman, M.D. | |
| 23D. ADDRESS
2 East Read Street | | 23E. DEGREE
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
6/5/69 | | 24C. NAME OF CEMETERY or CREMATORY
Church Home and Hospital | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Robert E. Gabe, M.D. | | 25C. FUNERAL DIRECTOR
57 HOSPITAL DISPOSAL | |
| 25D. ADDRESS | | | | | |

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "to", "the", and "and" are faintly visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "and" and "the" are faintly visible.

Handwritten signature or name, possibly "John Thompson", written in a cursive style.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5799

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5799

| | | | | | |
|---|-------------------------|---|-------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) William Brown | | 2. DATE AND HOUR OF DEATH
June 3, 1969 6:00 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 14-03 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
39 Provident Hospital
1514 Division Street
Baltimore, Maryland 21217 | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
2034 Druid Hill Avenue | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
72 | 9. AGE (In years last birthday)
72 | 10. Under 1 Yr. Months Days
9 9 9 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 13. FATHER'S NAME
? | | 14. MOTHER'S MAIDEN NAME
? | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-07-4914 | | 17. INFORMANT
Mary Reed (Friend) ADDRESS
2034 Druid Hill Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
4868 I
Pneumonitis | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Pneumonitis
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Senility | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-28-69 to 6-3-69 and that (I) (we) last saw the deceased alive on 6-3-69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Ahsan S. Khan | | DEGREE
MD | | 23B. DATE SIGNED
6-3-69 | |
| 23C. PHYSICIAN'S NAME (Type)
AHSAN S. KHAN | | 23D. ADDRESS
Provident Hospital
1514 Division Street - Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/9/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt Calvary Cemetery | |
| 24D. LOCATION
A A County MD | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | | |
| 25B. NAME OF REGISTRAR
Valerie E. Taylor, MD | | 25C. FUNERAL DIRECTOR
Adolphus Halstead ADDRESS
1206 W North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. |
|---|----------------------|---|--|---|
| 69 5300 | | 69 5300 | | 69 5300 |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH |
| | | MERCY D. PAYNE | | 8 June 1969 3:40 A.M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

34 Bon Secours Hospital | | A. STATE
MD. | | |
| | | B. COUNTY
14-02 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
1435 ARGYLE AVENUE 21217 | | |
| 5. SEX
FE | 6. RACE
C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-30-09 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday)
59 |
| | | | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 11. BIRTHPLACE (State or foreign country)
VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME
William Brown | | 14. MOTHER'S MAIDEN NAME
MARY Liza Lee | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
As. Chant |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

154.1 I
Metastatic Carcinoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of rectum
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12 APRIL 1969 to 8 JUNE 1969, that (I) (we) last saw the deceased alive on 8 JUNE 1969 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Chaweng Onzkarawan M.D. | | 23B. DATE SIGNED
8 June 1969 | | 23C. PHYSICIAN'S NAME (Type)
CHAWENG ONZKARAWAN, M.D. |
| 23D. ADDRESS
Bon Secours Hosp. 2025 W. Fayette St. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
6/12/69 | 24C. NAME OF CEMETERY or CREMATORY
Lynchburg | | 24D. LOCATION (City, town, or county) (State)
Virginia |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
J. E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
5 A Halstead 1206 W North Ave |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5801 | |
|--|---------------------|---|---|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) AGNES JONES | | 2. DATE AND HOUR OF DEATH
6-7-69 11:00 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
BOLTON HILL NURSING CENTER | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
8. COUNTY 1-01
C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 816 S. ELLWOOD AVE. | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
12-12-01 | 9. AGE (In years lost <input type="checkbox"/> day)
67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Bernhardt Peterson | | | 14. MOTHER'S MAIDEN NAME
Peterson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
— | 17. INFORMANT
ADMISSION RECORD
ADDRESS | | |
| 18. 412.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Cardiac Decomposition
(B) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
5 yrs. |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 5 19 69 to June 7 19 69 , that (I) (we) lost the deceased alive on June 5 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE
Clarence W. Ledoux
DEGREE
Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
6/7/69 | |
| 23C. PHYSICIAN'S NAME (Type)
CLARENCE W. LEDOUX
DEGREE | | | | 23D. ADDRESS
3023 Eastern Ave Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-10-69 | | 24C. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | |
| 24D. LOCATION
Balto | | 24E. LOCATION
Balto | | 24F. LOCATION
Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Spaffmann Funeral Home - 3018 Hudson St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5802

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 5802

| | | | | | |
|---|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) MARGARET WEST | | 2. DATE AND HOUR OF DEATH
JUNE 3, 1969 2:25 PM. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CHURCH HOME AND HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 3-02 | | C. CITY OR TOWN
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
CHURCH HOME AND HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
F | | 6. RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 8. DATE OF BIRTH
8-5-09 | | 9. AGE (in years last birthday)
59 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
PHILADELPHIA | |
| 12. CITIZEN OF WHAT COUNTRY
AMERICA | | 13. FATHER'S NAME
HARRY HALL | | 14. MOTHER'S MAIDEN NAME
FLORENCE SHRESSLER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
ROBERT WEST (SON) | |
| ADDRESS
SAME | | 18. CAUSE OF DEATH
Coronary Vascular Disease (thrombosis)
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Generalized Arteriosclerosis
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
HOURS
YEARS | | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
MYOCARDIAL INFARCTION, | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MONTHS | | | |
| MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that he (this hospital) attended the deceased from June 2, 1969 to June 3, 1969 that he (we) last saw the deceased alive on June 3, 1969 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
Cezar A. Lopez MD | | | | 23B. DATE SIGNED
JUNE 3 1969 | |
| 23C. PHYSICIAN'S NAME (Type)
CEZAR A. LOPEZ MD | | | | 23D. ADDRESS
CHURCH HOME AND HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
JUNE 6 1969 | | 24C. NAME OF CEMETERY or CREMATORY
SACRED HEART CEM | |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (City, town, or county) | | 24F. LOCATION (City, town, or county) | |
| GERMAN HILL RD MD | | GERMAN HILL RD MD | | GERMAN HILL RD MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
JUNE 9 1969 | | 25C. FUNERAL DIRECTOR
THE DIPPEN BROS INC 1800 E LOMBARD | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

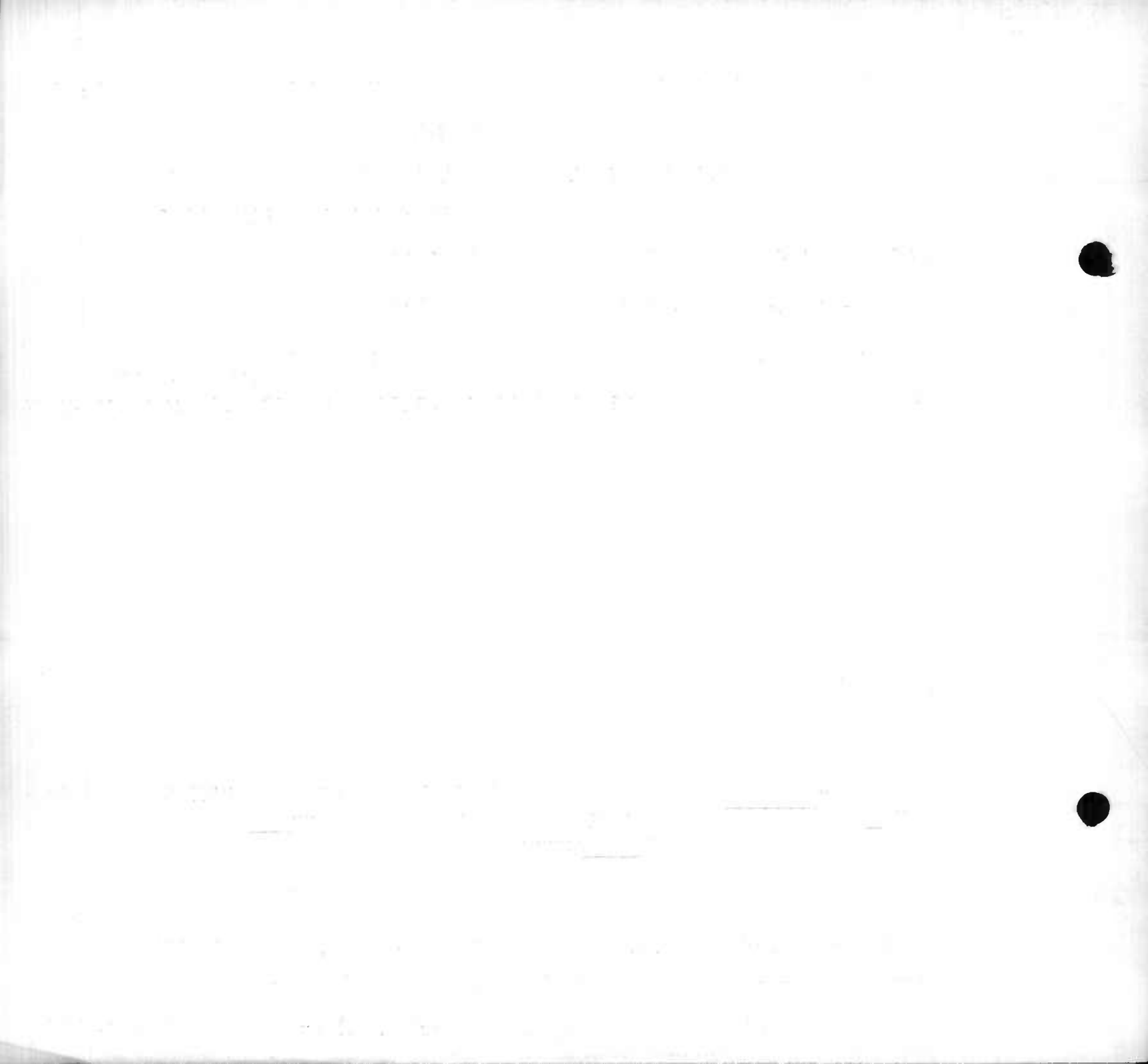
69 5803

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5803

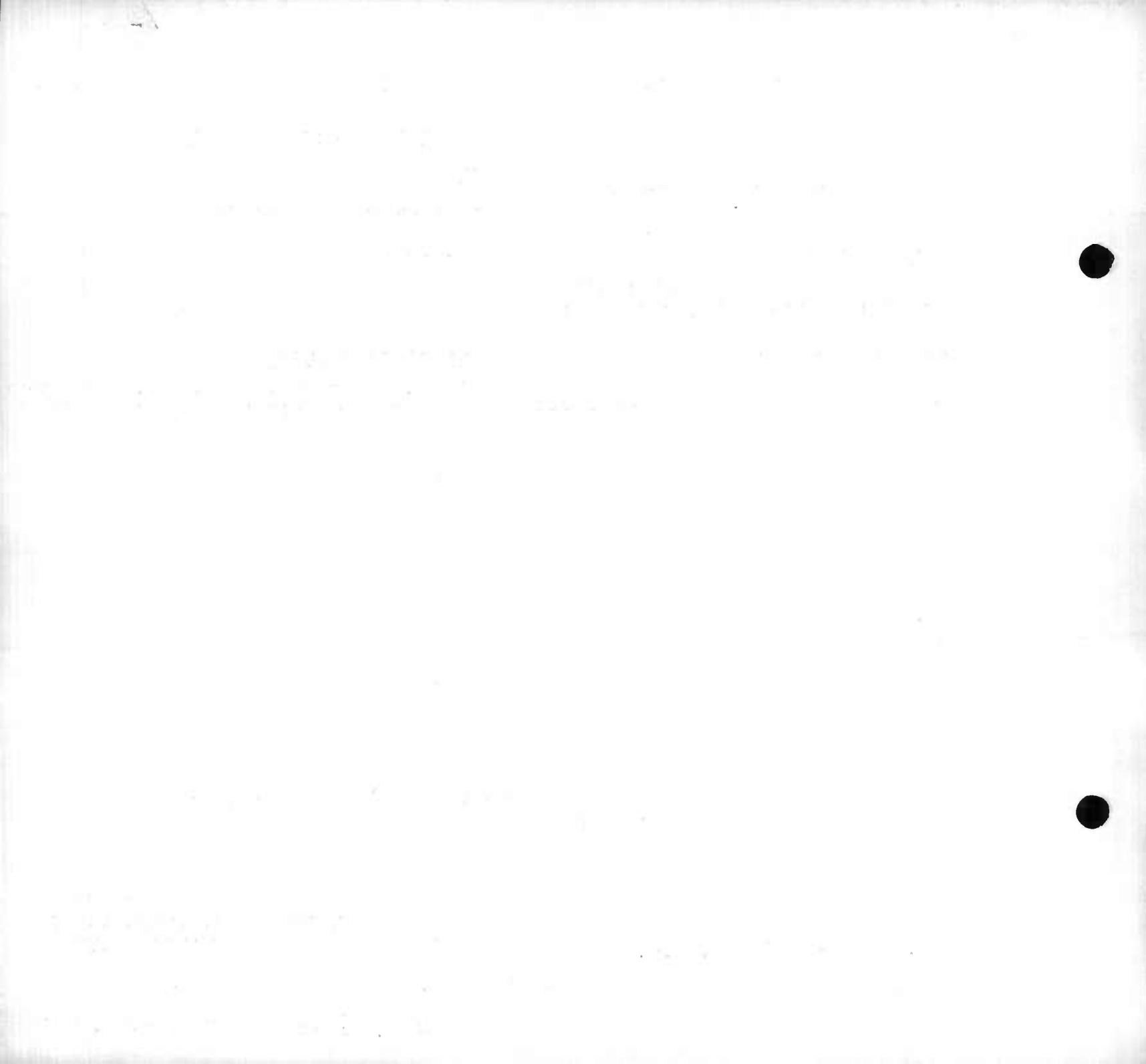
| | | | | | |
|---|--|---|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) WYANT GEORGE E | | 2. DATE AND HOUR OF DEATH
JUNE 5 1969 2:45P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY 25-53 | | C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 4 23 77 | | 9. AGE (In years last birthday) 92 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BREWER - FIREMAN | | 10B. KIND OF BUSINESS OR INDUSTRY BREWERY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY | | 13. FATHER'S NAME NICHOLAS WYANT | | 14. MOTHER'S MAIDEN NAME SARAH (UNKNOWN) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215 05 4072 | | 17. INFORMANT BALTO MD 21229 ST AGNES HOSP RECORDS WILKENS & CATON | |
| 18. CAUSE OF DEATH
412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arterio-Sclerotic C-V Disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
None | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Many years | | | |
| 19A. DATE OF OPERATION 1 5/24/69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene, (R) foot & (R) leg | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 23 1969 to JUNE 5 1969 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 5 1969 and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | |
| 23A. SIGNATURE Morton B. Blumberg M.D. | | 23B. DATE SIGNED 6/5/69 | | 23C. PHYSICIAN'S NAME (Type) MORTON B. BLUMBERG M.D. | |
| 23D. ADDRESS ST AGNES HOSP BALTO MD 21229 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 6-7-69 | |
| 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | | 24D. LOCATION Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT. JUN 9 1969 | |
| 24F. NAME OF REGISTRAR John E. J. [illegible] | | 24G. FUNERAL DIRECTOR Howard H. Hubbard | | 24H. ADDRESS 4107 Wilkens Ave. 21229 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 69 5804 | |
|---|---------|--|------------------|---|------------------------|--|------------------------------|
| 69 5804 | | | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | HUMPHRIES, HARRY S. | | JUNE 5, 1969 2:00P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 40 ST. AGNES HOSPITAL | | | | MARYLAND ANNE ARUNDEL 52-00 | | | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | GLEN BURNIE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 7227 CROWN RD 21061 | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months | 10. Under 24 Hrs. Ooys | 10. Under 24 Hrs. Hours Min. |
| MALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 09/01/07 | 61 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| METER INSTALLER | | | | BALTIMORE GAS & ELECTRIC CO | | MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| FRANCIS HUMPHRIES | | | | ALICE (NEE GANLEY) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES WW II | | | | 212-05-6011 | | Ann M. Humphries 7227 Crown Rd, Glen Burnie ST. AGNES HOSPITAL RECORDS 21061 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | Carcinoma of the lung with metastasis | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 7 1969 to JUNE 5 1969 that (I) (we) last saw the deceased alive on JUNE 5 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| A. Shams, M.D. | | | | 06 05 69 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| A. SHAMS-PIRZADEH, M.D. | | | | BALTIMORE MARYLAND 21229 | | | |
| | | | | ST. AGNES HOSP: CATON & WILKENS AVES. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 6-9-69 | | Baltimore National Cem. | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUN 9 1969 | | Robert E. Taylor, M.D. | | Howard H. Hubbard | | 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **69 5805**

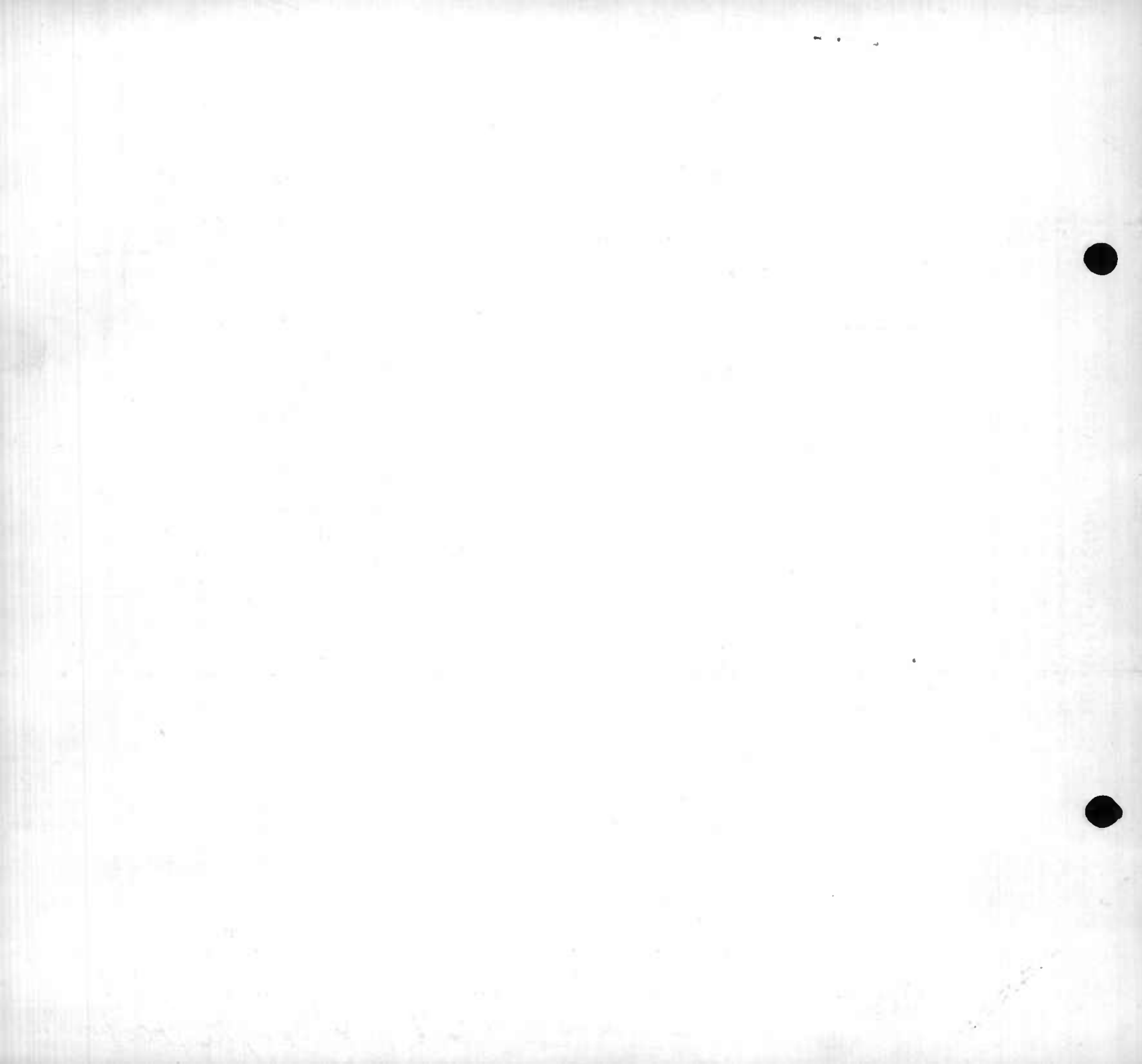
| | | | |
|--|--------------------------|---|---|
| BIRTH NO. 69-10190 69 5805 | | DATE AND HOUR OF DEATH
JUNE 4, 1969 6:30 P. M. | |
| 1. NAME OF DECEASED
(Type or Print) BABY BOY FORAKIS | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY 26-25 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
34 BON SECOURS HOSPITAL | | C. CITY OR TOWN BALTIMORE 21223 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 8249 RAPPOLLA ST. | |
| 5. SEX MALE | 6. RACE CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 4, 1969 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 1 If Under 1 Yr. Months: Days: Hours: Min. 21 |
| 11. BIRTHPLACE (State or foreign country) UNITED STATES | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 13. FATHER'S NAME JOHN FORAKIS | | 14. MOTHER'S MAIDEN NAME ANGELIKI PROTOFANOOSIS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT Hospital Records ADDRESS | |
| 18. 7769 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE Atelactasis
DUE TO, OR AS A CONSEQUENCE OF:

(B) Prematurity
DUE TO, OR AS A CONSEQUENCE OF:

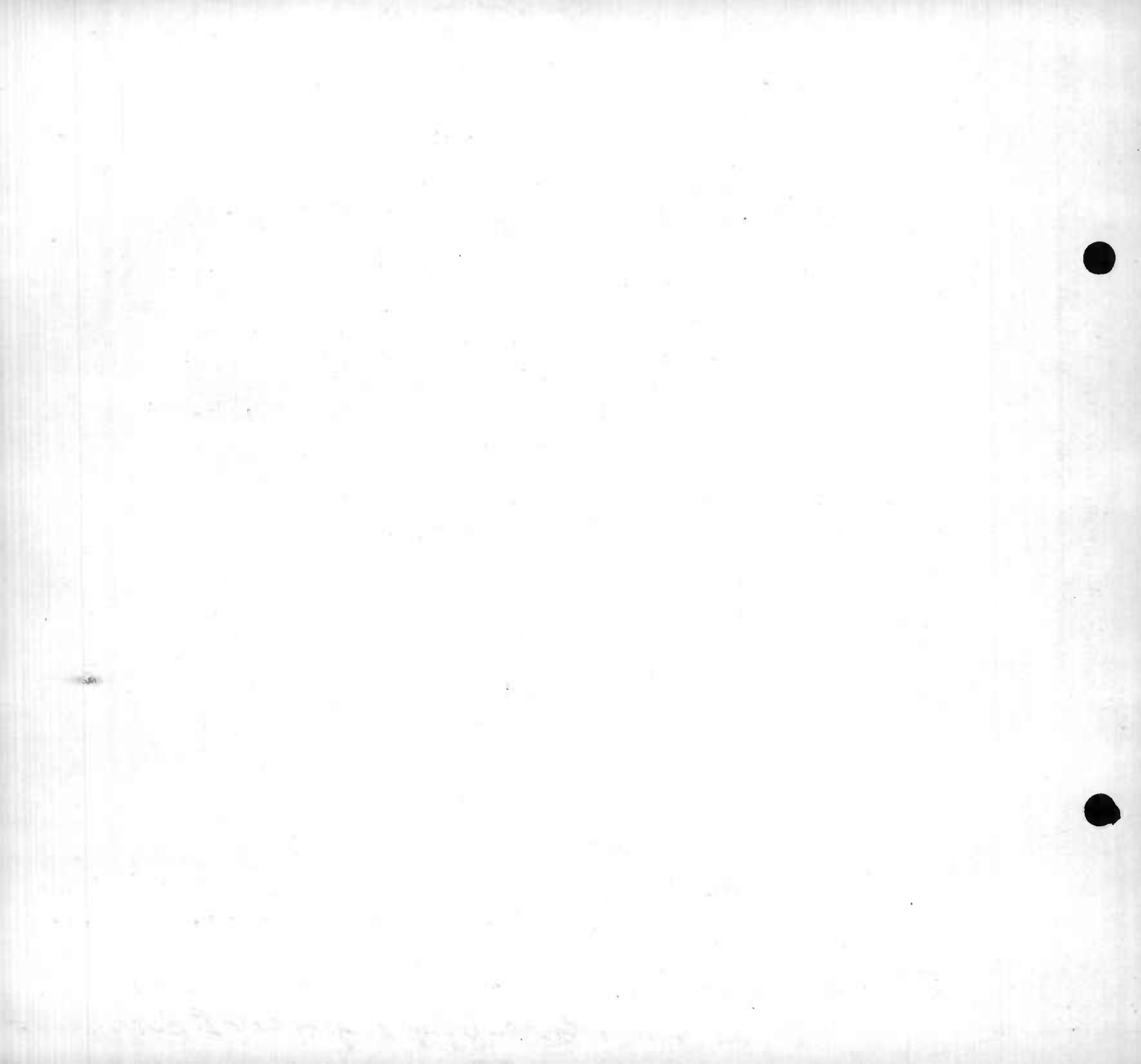
(C) | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-4-1969 to 6-4-1969 , that (I) (we) last saw the deceased alive on 6-4-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Estrellita P. Trias M.D. DEGREE | | 23B. DATE SIGNED 6-4-69 | |
| 23C. PHYSICIAN'S NAME (Type) ESTRELLITA P. TRIAS M.D. DEGREE | | 23D. ADDRESS BON SECOURS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 6/5/69 | 24C. NAME OF CEMETERY OR CREMATORY St Peters Cem | 24D. LOCATION (City, town, or county) (State) Beth Md |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 9 1969 | | 25B. NAME OF REGISTRAR Robert E. Talbot M.D. | |
| | | 25C. FUNERAL DIRECTOR William J. Kenny Jr ADDRESS 1600 Holler | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 5-200 | | 69 5806 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5806 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) <i>MAMIE E. SCHOCK HARRY ELIZABETH</i> | | | |
| 2. DATE AND HOUR OF DEATH
<i>6-4-69</i> | | | | <i>6¹⁰ P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>26-10</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>31</i>
<i>BALTIMORE CITY HOSPITALS</i>
<i>4940 Eastern Ave</i>
<i>Baltimore, Maryland #21224</i> | | | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
<i>Female</i> | | | | 6. RACE
<i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
<i>10/12/1888</i> | | | | 9. AGE (In years
lest birthday)
<i>79</i> | | If Under 1 Yr. Months Days If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | 13. FATHER'S NAME
<i>Joseph Simon</i> | | | |
| 14. MOTHER'S MAIDEN NAME
<i>Elizabeth</i> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
<i>BCH Records: 4940 Eastern Ave</i>
<i>Baltimore, Maryland #21224</i> | | | |
| 18. <i>432.91</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>Basilar Artery Thrombosis</i>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>12 hrs</i> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) <i>Arteriosclerotic Vascular Disease years</i>
DUE TO, OR AS A CONSEQUENCE OF:
(C)..... | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>June 4</i> 19 <i>69</i> to <i>June 4</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>June 4</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>William W. Brockman</i> | | | | 23B. DATE SIGNED
<i>June 4, 1969</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>William W. Brockman</i> | | | | 23D. ADDRESS
<i>4940 Eastern Avenue, Baltimore, Md.</i>
<i>Balt. City Hosp 21224</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<i>4/7/69</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Oak Lawn Cem.</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 9 1969</i> | | 25B. NAME OF REGISTRAR
<i>John E. Haber, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>BDAB BOWSKI & SIF E. Baltimore St.</i> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5807 | |
|--|-------------------------|---|--|---|---|
| 69 5807 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Hattie L. Riddlemoser</i> | | 2. DATE AND HOUR OF DEATH
<i>6/6/69</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>Frederick</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>33 The Johns Hopkins Hospital</i> | | | C. CITY OR TOWN
<i>Frederick</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | E. STREET AND NUMBER
<i>311 W. Fifth Street</i> | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>5/22/00</i> | 9. AGE (In years last birthday)
<i>69</i> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>House-work</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U. S.</i> | | | | | |
| 13. FATHER'S NAME
<i>George E. Lare</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Margaret E. Hamilton</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>214-10-1100A</i> | | 17. INFORMANT
<i>Charles E. Riddlemoser</i> ADDRESS
<i>311 W. 5th St., Frederick, Md. 21701</i> | |
| 18. <i>183.0 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Epsis</i>
(B) <i>Abdominal Aneurysm</i>
DUE TO, OR AS A CONSEQUENCE OF:
<i>C. of Atherosclerosis</i>
(C) <i>Dehydration</i> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<i>4/10/69</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Subtotal. Abstruction</i> | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <i>it</i> (this hospital) attended the deceased from <i>5/29/69</i> 19 <i>69</i> to <i>6/6/69</i> 19 <i>69</i> that <i>it</i> (we) last saw the deceased alive on <i>6/6</i> 19 <i>69</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>it</i> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>[Signature]</i> | | | 23B. DATE SIGNED
<i>6/6/69</i> | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>L.R. Tumbler MD</i> | | | 23D. ADDRESS
<i>Johns Hopkins Hospital</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6/9/69</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Frederick Memorial Park</i> | |
| 24D. LOCATION
<i>Frederick, Maryland 21701</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 9 1969</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, MD</i> | | 25C. FUNERAL DIRECTOR
<i>Frederick R. Smith Jr.</i> ADDRESS
<i>Frederick, Md.</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

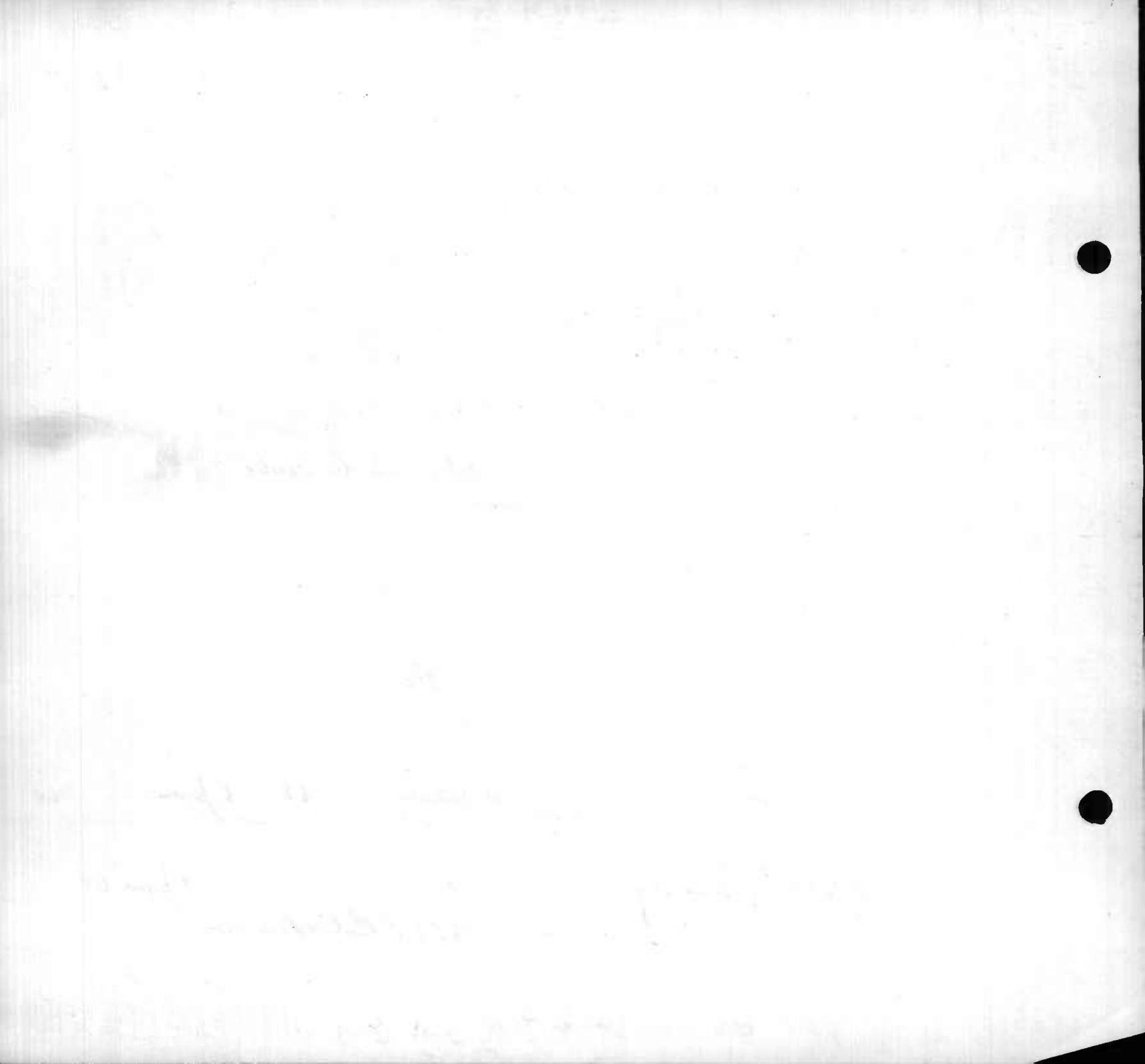
| BIRTH NO. 69 5808 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5808 | | | |
|---|------------------|---|--|--|--|---|--|------------------|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) CHARLES S. JACOBS | | | | 2. DATE AND HOUR OF DEATH
5 JUNE 1969 8:45 P.M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 23-02 | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
SOUTH BALTIMORE GENERAL HOSP. 43 | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| | | | | E. STREET AND NUMBER
1507 S. CHARLES ST. | | | | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
31 DEC 1893 | 9. AGE (In years last birthday)
76 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sup. Retired | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sup. Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY
Sec. Sec. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
Henry Jacobs | | | | | | | | |
| 14. MOTHER'S MAIDEN NAME
Linnie? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | | | | |
| 16. SOCIAL SECURITY NO.
212-14-1355 | | | 17. INFORMANT
Reed's | | | | | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
ELECTROLYTE IMBALANCE | | | 19. IMMEDIATE CAUSE
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
PULMONARY EMPHYSEMA
(B) CHRONIC BRONCHITIS
(C) | | | | | | | | |
| 19A. DATE OF OPERATION
6-9-69 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 MAY 19 69 to 5 JUNE 19 69 that (I) (we) last saw the deceased alive on 5 JUNE 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Barry Alan Blum MD | | | | 23B. DATE SIGNED
6-5-69 | | 23C. PHYSICIAN'S NAME (Type)
BARRY ALAN BLUM MD | | | | | |
| 23D. ADDRESS
SOUTH BALTIMORE GENERAL HOSPITAL | | | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | | | |
| 24B. DATE
6-9-69 | | 24C. NAME OF CEMETERY or CREMATORY
Louden Park Cem. | | 24D. LOCATION (City, town or county) (State)
Balto, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | | | | |
| 25B. NAME OF REGISTRAR
E. J. Jaber, R.D. | | 25C. FUNERAL DIRECTOR
McCullough | | 25D. ADDRESS
130 E. Fort Ave. 21230 | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

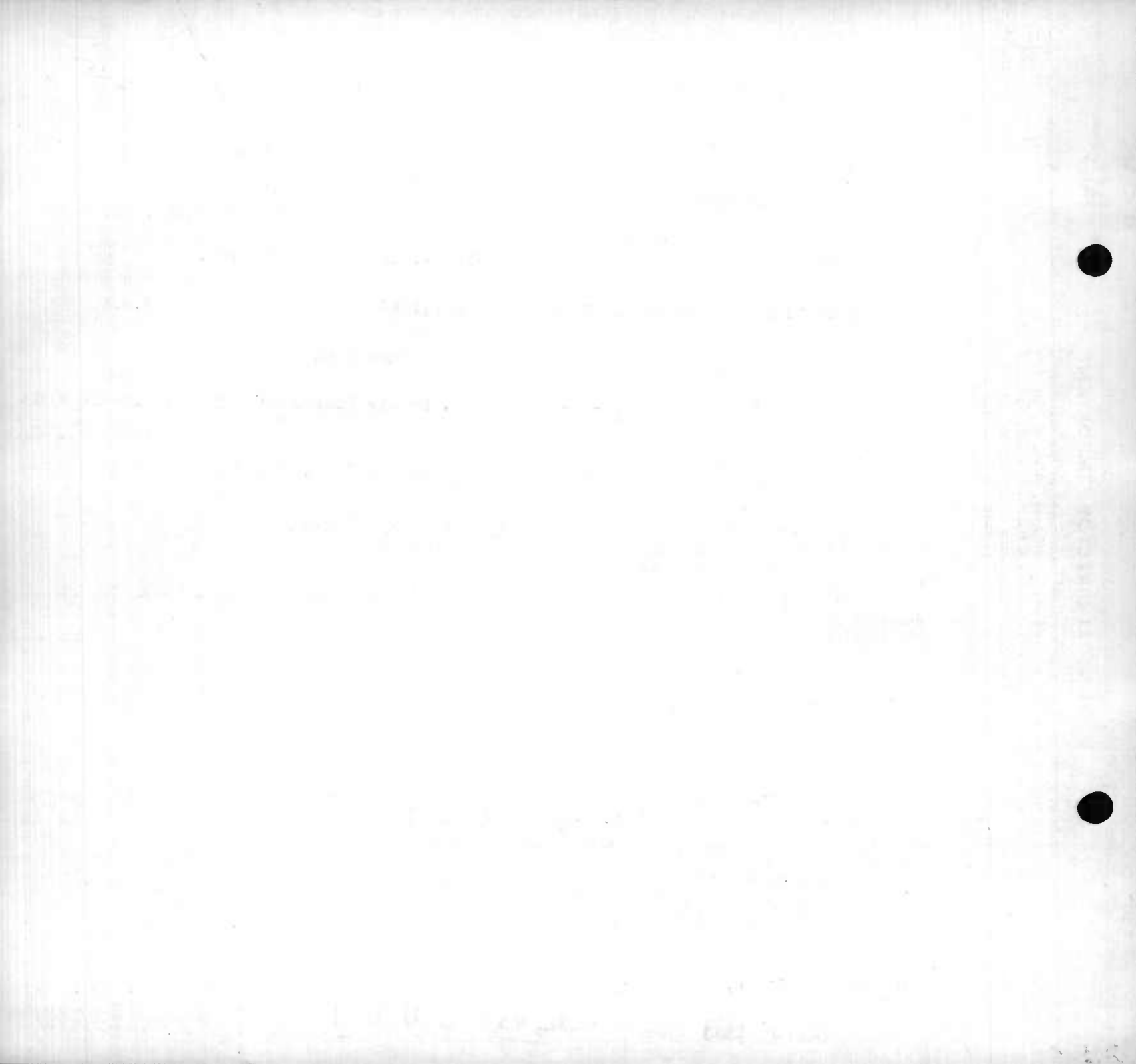
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5809 |
|---|---------------------|---|---|---|
| BIRTH NO. | | 69 5809 | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) Florence May Young | | 2. DATE AND HOUR OF DEATH
June 6, 1969 6 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md 8. COUNTY 27-55 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 The Wesley Home, Inc | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER
2211 W Rogers Ave | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 12, 1887 | 9. AGE (In years lost birthday) 87 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerical Work | | 10B. KIND OF BUSINESS OR INDUSTRY
Good Will Industries | | 11. BIRTH PLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Edward Davis | | |
| 14. MOTHER'S MAIDEN NAME
Sarah Elizabeth Turner | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No - | | |
| 16. SOCIAL SECURITY NO.
218 09 9726A | | 17. INFORMANT
The Wesley Home Records | | |
| 18. CAUSE OF DEATH
412.4 I | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Anterior-sclerotic cardio-vascular disease | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| (C) | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 25 September 1968 to 6 June 1969 , that (I) (we) last saw the deceased alive on 3 June 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
John W. Barnaby | | 23B. DATE SIGNED
7 June 69 | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)
Dr John W. Barnaby | | 23D. ADDRESS
1657 E Bolbrede Ave | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
JUN 9 1969 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park |
| 24D. LOCATION (City, town, or county)
Baltimore, Md | | (State)
Md | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
James E. Taylor, MD | | 25C. FUNERAL DIRECTOR
Burgees Funeral Home |
| ADDRESS
3631 Falls Rd | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5810 |
|--|-------------------------|---|---|---|
| BIRTH NO. | | 69 5810 | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| Emil F. Conrad | | 6-6-69 | | 2:15 P. M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 House in the Pines
Belair Road | | A. STATE Maryland
B. COUNTY 27-31 | | |
| | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
3212 Tyndale Avenue, Balto, Md. 21214 | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jun 21, 1889 | 9. AGE (In years last birthday) 79 yrs.
If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Letter Carrier | | 10B. KIND OF BUSINESS OR INDUSTRY
Postal Service | | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | 13. FATHER'S NAME
Unknown | | |
| 14. MOTHER'S MAIDEN NAME
Euna Nobe | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No none | | |
| 16. SOCIAL SECURITY NO.
218-26-8710 | | 17. INFORMANT ADDRESS
Mrs. Bessie Conrad 3212 Tyndale Avenue 21214 | | |
| 18. 437.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Quadruplegia
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Cerebral arteriosclerosis | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 mos | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 1957 to June 6, 1969 , that (I) we last saw the deceased alive on May 27, 1969 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) not view the body after death. | | | | |
| 23A. SIGNATURE
Ronald Jandorf | | 23B. DATE SIGNED
6-6-69 | | 23C. PHYSICIAN'S NAME (Type)
R Donald Jandorf |
| 23D. ADDRESS
7403 Hartford Rd | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | |
| 24B. DATE
Jun 9, 1969 | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Parkwood, Balto Co. Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
W. E. Taylor, R.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Frank B. Leitz 814 W 36 St. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|---|--|---|--|--|--|
| BIRTH NO. <u>69. 5811</u> | | | | | REG. NO. <u>69 5811</u> | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Pennsylvania</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>6/4/69 12 PM</u> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
<u>UNIVERSITY HOSPITAL</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Pa</u> B. COUNTY <u>HANOVER</u> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>UNIVERSITY HOSPITAL</u> | | | | | C. CITY OR TOWN
<u>HANOVER</u> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | E. STREET AND NUMBER
<u>12 SPRENKLE AVE.</u> | | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>5/19/69</u> | 9. AGE (In years last birthday)
<u>17</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>INFANT</u> | 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | | |
| 13. FATHER'S NAME
<u>ROBERT Rickrode</u> | | | 14. MOTHER'S MAIDEN NAME
<u>ELSIE BAUMGARDNER</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>Robert Rickrode</u> ADDRESS
<u>12 Sprenkle Ave. Hanover, Pa.</u> | | | | |
| 18. <u>74661</u> CAUSE OF DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>CARDIO - PULMONARY</u> | | | | | <u>1 hour</u> | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>ARREST</u> | | | | | | | | | |
| (C) <u>CHD</u> | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>PREMATURITY</u> | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>3/26/69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Pulmonary valve closure</u> | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/23</u> 19 <u>69</u> to <u>6/4</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/4</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>J. Deane - Almond</u> | | | | | 23B. DATE SIGNED
<u>6/4/69</u> | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u> </u> | | | | | 23D. ADDRESS
<u> </u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6-6-1969</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Penn Memorial Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Hanover York Co Pa.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>11/19 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Zeller, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u> </u> | | ADDRESS
<u>Hampstead Ind.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5812 |
|---|--|--|--|---|
| BIRTH NO. 69 5812 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) BROWN, Howard | | 2. DATE AND HOUR OF DEATH
6-6-69 3:30 P. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
University Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MD B. COUNTY BALTO | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
University Hospital | | C. CITY OR TOWN
BALTO - 21204 | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 5. SEX male | | 6. RACE Can. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Police | | 10B. KIND OF BUSINESS OR INDUSTRY
BIO RR. | | 11. BIRTHPLACE (State or foreign country)
MD |
| 13. FATHER'S NAME
BROWN, Charles | | 14. MOTHER'S MAIDEN NAME
Rebecca Edwards | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
--- | | 17. INFORMANT George Bockrell ADDRESS Cincinnati, OHIO |
| 18. 7-22-91 | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Asystole | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 MIN |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) BRADYCARDIA
DUE TO, OR AS A CONSEQUENCE OF: | | 10 MIN |
| (C) HYPOXIA | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
EVA | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
--- | | 20A. AUTOPSY? (Yes or No)
NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
--- | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (1) (this hospital) attended the deceased from 6-1-69 19 to 6-6-69 19 that (2) (we) last saw the deceased alive on 6-6-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
J. F. AITA MD | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
6-6-69 |
| 23C. PHYSICIAN'S NAME (Type)
J. F. AITA MD | | 23D. ADDRESS
University Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-9-1969 | | 24C. NAME of CEMETERY or CREMATORY
Druid Ridge Cemetery |
| 24D. LOCATION (City, town, or county)
Pikesville Maryland | | 24E. IS TOL | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, MD | | 25C. FUNERAL DIRECTOR
Wm. C. Carr 3 Branks Town |
| | | | | ADDRESS
1052 York Rd Towson, MD |

D-540

69 5813 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5813

REG. NO.

BIRTH NO.

| | | | |
|---|---|--|---|
| 1. NAME OF DECEASED
(Type or Print)
LOUIS A. DEMELY Demely, Sr. | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
6 4 69 8:06 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
South Balto. General Hospital
D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 4, 1969 8:06 a.m. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 25-33 | | | |
| 6. SEX
Male | 7. RACE
White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN
Balto.
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH
July 27, 1891
10. AGE (In years lost birthday) 77 | | E. STREET AND NUMBER
2127 Annapolis Rd. 21230 | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 13. FATHER'S NAME
Emil Demely | |
| 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME
Edith Rockwell | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)
Yes W. W. I | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
Mr. Louis A. Demely, Jr. | | ADDRESS
21230 Annapolis Rd. | |
| 19. 412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
Gouty Arthritis | | CAUSE OF DEATH
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
6/7/69 | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Park Cemetery | 24D. LOCATION (City, town, or county) (State)
Woodlawn, Maryland Balto. Co. |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | 25C. FUNERAL DIRECTOR
McGulley T. H. | ADDRESS
237 Patapsco Ave. 21225 |

Robert M. Vane

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5814 | |
|--|------------------|--|---|--|--|
| BIRTH NO. 68-10520 | | 69 5814 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Alicia Evans | | | 2. DATE AND HOUR OF DEATH
6/5/69 1:15 AM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
42 Sinai Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 27-16
C. CITY OR TOWN Balto.
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3401 Dupont Ave | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/7/68 | | 9. AGE (In years lost birthday) 11 mos 11 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) MD. USA | |
| 13. FATHER'S NAME Nathaniel EVANS | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) none | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT L. Robinson ADDRESS MD Sinai Hos |
| 18. 205.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
sepsis anemia | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
congestive heart failure
myelogenous leukemia | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
? sepsis | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
II | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/2/69 19 to 6/5/69 19, that (I) (we) last saw the deceased alive on 6/5/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Lawrence D. Robinson | | | | 23B. DATE SIGNED 6/5/69 | |
| 23C. PHYSICIAN'S NAME (Type) — | | | | 23D. ADDRESS Sinai Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 6/7/69 | | 24C. NAME OF CEMETERY OR CREMATORY Pinetown Mem. PK. | |
| 24D. LOCATION (City, town, or county) ANNAPOLIS, MD. | | 24E. STATE (State) MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 9 1969 | | 25B. NAME OF REGISTRAR James E. Taylor R.E. | | 25C. FUNERAL DIRECTOR Wm. J. Robinson ADDRESS 1701 W. Calhoun St. Balt. Md | |

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2/1
0

www

9/21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5815 | |
|---|----------------------------|--|--|--|--|
| BIRTH NO. 69-10046 | | 69 5815 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) BABY BOY LEV | | | 2. DATE AND HOUR OF DEATH
6.6.69 5:55 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
SINAI HOSPITAL OF BALTIMORE, BELVEDERE AVE. AT GREENSPRING, BALTIMORE, MD. 21215. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MD. B. COUNTY 21215.
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3901 Pinkney Road. | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6.5.69 | 9. AGE (In years lost birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
23 1 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD. | |
| 13. FATHER'S NAME
Mani | | | 14. MOTHER'S MAIDEN NAME
MINNA LEV. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Hosp. Records | |
| 18. 7761 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
SEVERE HYALINE MEMBRANE
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: DISEASE.
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6.5.1969 to 6.6.1969 , that (I) (we) lost saw the deceased alive on 6.6.1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Pratibha Joshi | | | | 23B. DATE SIGNED
6-6-69 | |
| 23C. PHYSICIAN'S NAME (Type)
PRATIBHA JOSHI | | 23D. ADDRESS
MD. BELVEDERE AVE. AT GREENSPRING, BALTO. MD. 21215. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE
6/6/69 | 24C. NAME of CEMETERY or CREMATORY
Not Canned | | 24D. LOCATION (City, town, or county) (State)
Balto MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
John E. Johnson | | 25C. FUNERAL DIRECTOR
Frederick & Son, Inc | |
| | | | | ADDRESS
9610 Reisterstown Rd | |

Handwritten text, possibly "The House"

Handwritten text, possibly "No"

Handwritten text at the bottom of the page, possibly a signature or date.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5816 | |
|--|-------------------------|--|---|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) BIRX JR. HENRY CHRISTIAN | | 2. DATE AND HOUR OF DEATH
6 JUNE 69 3:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY AA CO. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SOUTH BALTIMORE GENERAL HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
GLEN BURNIE | |
| | | | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER
821 BROADVIEW BLVD. | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
31 JAN. 1889 | 9. AGE (In years lost birthday)
80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Const. Bldg. | | 10B. KIND OF BUSINESS OR INDUSTRY
Civil Services | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
HENRY C. BIRX - SR | | 14. MOTHER'S MAIDEN NAME
LOUISE BERLAND | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
220-05-1297 | | 17. INFORMANT
MARGARET BIRX - WIFE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ACUTE MYOCARDIAL INFARCTION | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) ARTERIOSELEROTIC CARDIOVASCULAR DISEASE WITH CONGESTIVE HEART FAILURE AND RIGHT BRANCH BRANCH BLOCK | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
PULMONARY EMPHYSEMA | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6 JUNE 19 69 to 6 JUNE 19 69 , that (I) (we) last saw the deceased alive on 6 JUNE 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Barry Alan Blum MD | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
6 JUNE 69 | |
| 23C. PHYSICIAN'S NAME (Type)
BARRY ALAN BLUM MD | | 23D. ADDRESS
SOUTH BALTIMORE GENERAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/9/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Western Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore MD | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | | |
| 25B. NAME OF REGISTRAR
John E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
R. P. Purnell | | | |
| | | ADDRESS
519 1st St. N. Glen Burnie | | | |

Small Buttercream Horse
821 BROWNISH 8220

MALE WHITE
X
21 Jan 1889 30
mossy and
longer (or) long

US ——— see also *Thymus* Oak - wire

④ *Thymus* *Thymus*
⑤ *Thymus* *Thymus*
in *Thymus* *Thymus* and
1 *Thymus* *Thymus* *Thymus*

231

— — —
e line e line
— — —

x e line

2000 *Thymus* *Thymus* *Thymus*
older *Thymus* *Thymus* *Thymus*
21 Jan 1889 30
21 Jan 1889 30

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5817 | |
|---|----------------------------|---|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>EVA DUNAWAY THOMPSON</u> | | 2. DATE AND HOUR OF DEATH
<u>6-5-69</u> <u>9:40 P. M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>4202 RIDGEWOOD AVE</u>
<u>00</u> | | | A. STATE
<u>MARYLAND</u> | | B. COUNTY
<u>28-41</u> |
| | | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER
<u>4202 RIDGEWOOD AVE</u> | | | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12-5-98</u> | 9. AGE (In years lost birthday)
<u>73</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>HENRY BURRELL</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>223-18-1358</u> | 17. INFORMANT <u>4202 Ridgewood Ave</u>
<u>(MRS.) Tilla Smith</u> <u>Balt. mds</u> | | |
| 18. <u>250.91</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

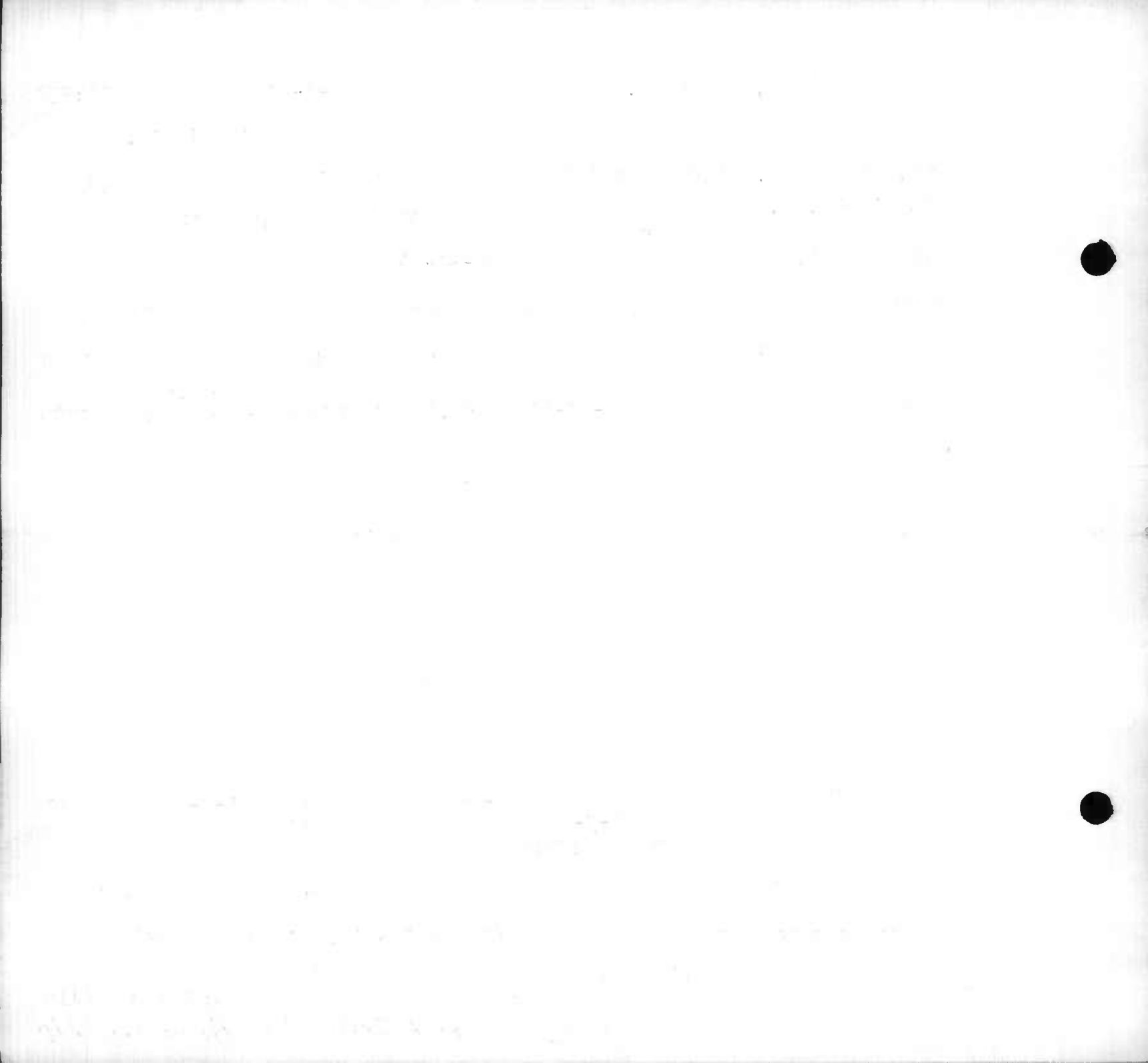
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>CEREBRAL ARTERIOSCLEROSIS</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR</u>
DUE TO, OR AS A CONSEQUENCE OF: <u>DISEASE</u>
(C) <u>DIABETES MELLITUS</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 yrs</u> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-30-1963</u> to <u>6-5-1969</u> , that (I) (we) lost saw the deceased alive on <u>6-5-1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Thomas W. Harris, M.D.</u> DEGREE | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>6-6-69</u> |
| 23C. PHYSICIAN'S NAME (Type)
<u>THOMAS W. HARRIS, MD</u> DEGREE | | | 23D. ADDRESS
<u>4200 EDMONDS AVE</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 24B. DATE
<u>6-9-69</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>Lively Hope Baptist Church</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Callao, Va.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 9 1969</u> | | 25B. NAME OF REGISTRAR
<u>John E. Fisher, MD</u> | | 25C. FUNERAL DIRECTOR
<u>Le Funeral Home</u>
<u>Le Funeral Home</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5818 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH REG. NO. 69 5818

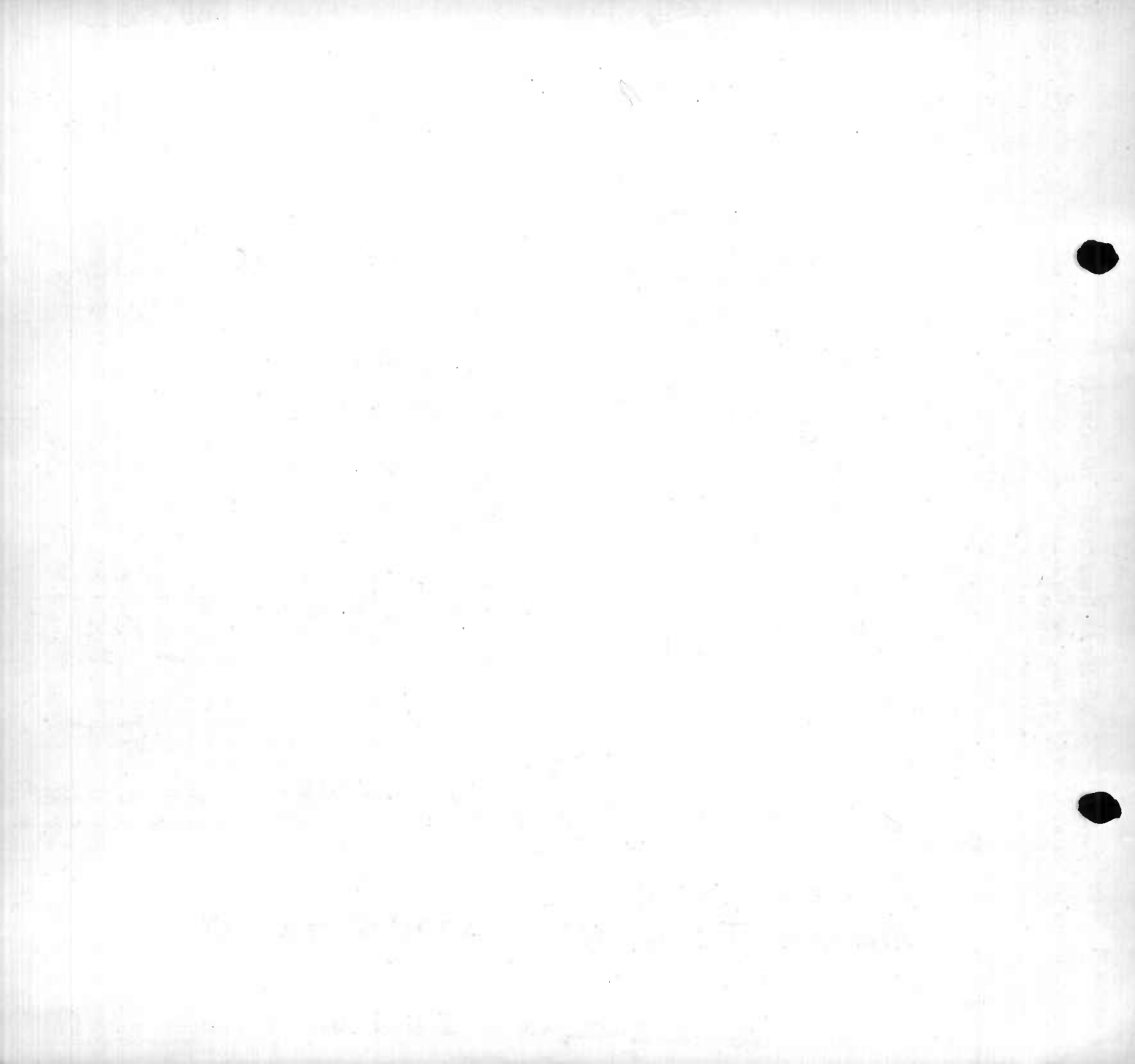
| | | | | | |
|--|---------|--|--------------------------|---|--------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | ENNIS, MELVIN W. | | 6-5-69 12:55PM. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST. AGNES HOSP. WILKENS & CATON
BALTIMORE, MD. 21228 | | | | A. STATE B. COUNTY
MARYLAND ANNA ARUNDEL CO. 52-00 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | | | SEV ERNA PARK YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER | | | | F. BOX #395 ZONE 21146 | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. If Under 1 Yr. Months Days |
| MALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 07-31-94 | 74 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| CHIEF | | RR - B+O. P.C.O. | | MARYLAND | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| ENNIS DEC 'D | | | LENA DOENGES DEC 'D | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 705-05-4857 | | RECORD ROOM
ST. AGNES RECORDS - WILKENS & CATON | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CORONARY THROMBOSIS | | | | 5-10 min | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | | (B) ATHEROSCLEROSIS, GENERALIZED | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | Glomerulosclerosis | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White <input type="checkbox"/> Nat White <input type="checkbox"/>
At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 5-28 19 69 to 6-5- 19 69 that (1) (we) last saw the deceased alive on 6-5-69 19 and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| JAMES G KANE MD | | | | 4/5/69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| JAMES G KANE MD | | | | ST AGNES HOSP. BALTO MD 21229 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 6-7-69 | | MEADOW RIDGE | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUN 9 1969 | | J. E. Taylor MD | | JOHN M. TAYLOR SONS ANNAPOLIS MD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 5819 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | 69 5819 | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| BIRTH NO. | | | | REG. NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>PATTERSON, Eddie V.</u> | | | | 2. DATE AND HOUR OF DEATH
<u>6/6/69</u> <u>4:25 P.M.</u> | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD.</u> 8. COUNTY <u>16-07</u> | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>Geo. Washington Nursing Home</u>
<u>607 Penn. Ave</u> | | | | C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 5. SEX <u>Female</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <u>12/15/1886</u> 9. AGE (In years last birthday) <u>82</u> | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Moses Gibson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Maruie</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>026-12-8944</u> | | | | 17. INFORMANT <u>Chart</u> ADDRESS | | | |
| 18. <u>427.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>CONGESTIVE CARDIAC DYSSEASE</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>PULMONARY EDEMA</u> | | | | <u>5 days</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | (C) <u>APOPLEXY / GENERALIZED ARTERIOSCLEROSIS</u> | | | | <u>1 wk.</u> | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>4-26</u> 19 <u>69</u> to <u>6-6</u> 19 <u>69</u> , that (1) (we) last saw the deceased alive on <u>6-6</u> 19 <u>69</u> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>Richard Tyson, MD.</u> OEGREE | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <u>6-6-69</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>RICHARD TYSON, MD.</u> DEGREE | | | | 23D. ADDRESS <u>2320 EUTAW PL. CITY -17-</u> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24B. DATE <u>6-9-69</u> | | | | 24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u> | | | |
| 24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> | | | | 24E. STATE (State) <u>Md.</u> | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1969</u> | | | | 25B. NAME OF REGISTRAR <u>Robert E. J. J. J.</u> | | | | 25C. FUNERAL DIRECTOR <u>Charles R. Law</u> ADDRESS <u>802 Madison Ave.</u> | | | |



W-405

69 5820 BALTIMORE CITY HEALTH DEPARTMENT

69 5820

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

SHERMAN (WILKENS) WILKINS

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

June 7, 1969

12:24 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BON SECOUR HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 7, 1969

12:24 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

15-03

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

3/21/1920

10. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1738 N. Smallwood St.

11. BIRTHPLACE (State or foreign country)

Puerto Rico

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

W. H. WILKINS

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Longshoreman

14B. KIND OF BUSINESS OR INDUSTRY

Port of Balto

15. MOTHER'S MAIDEN NAME

K. H. COLOMAN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW II

17. SOCIAL
SECURITY NO.

228-01-6122

18. INFORMANT

ADDRESS

K. H. WILKINS 700 Appleton St

19.

E 965 X

CAUSE OF DEATH

Gunshot wound of chest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxiation, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

In front of 1926 Harlem Avenue

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) June 7, 1969 12:08A.m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot/during argument

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/7/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/12/69

24C. NAME of CEMETERY or CREMATORY

3101 Bapt Church Greenwood Co VA

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1969

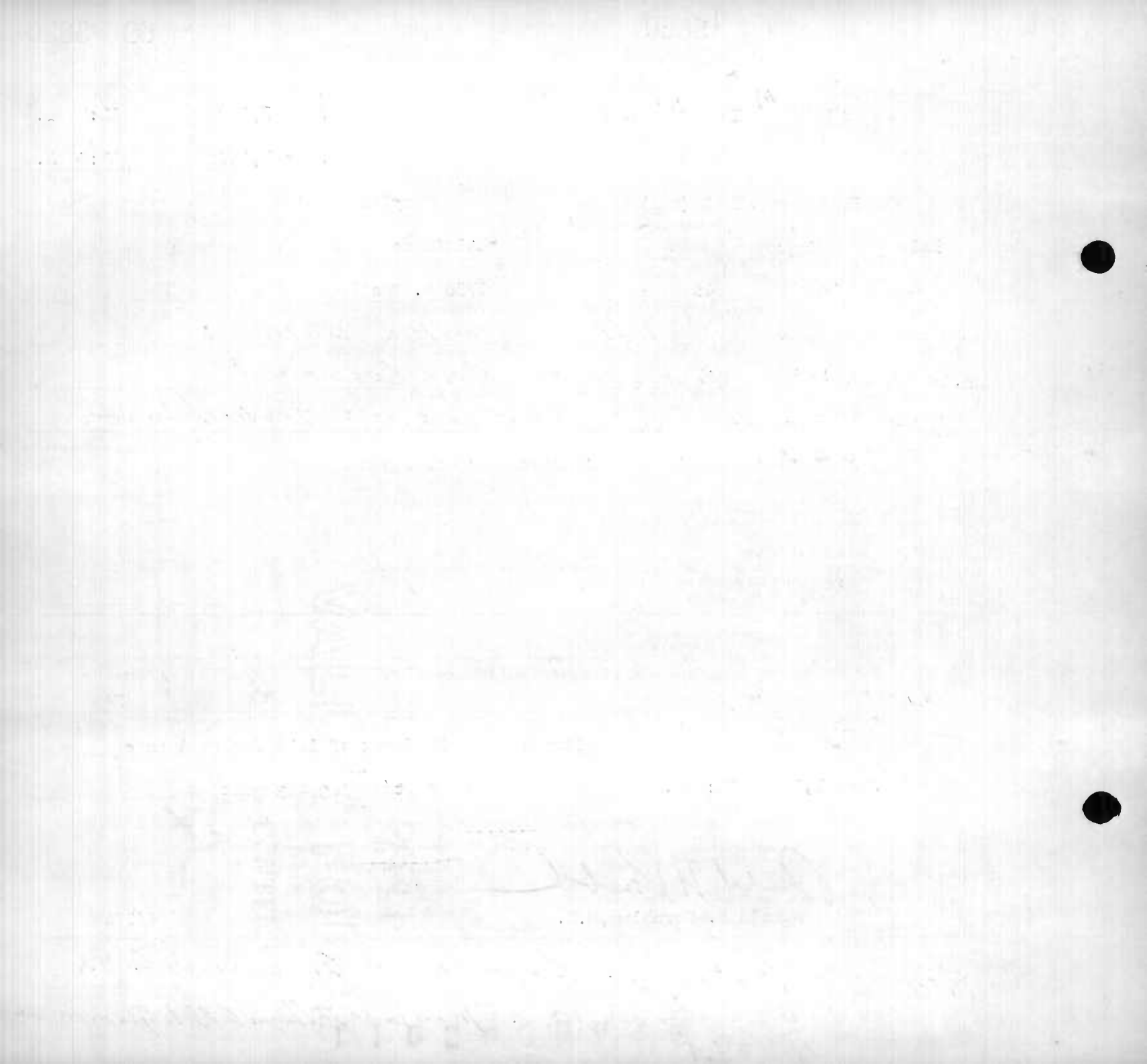
25B. NAME OF REGISTRAR

Robert E. Talley, M.D.

25C. FUNERAL DIRECTOR

Thomas H. Allen 638 N. G. on St

ADDRESS



D-652

69 5821 BALTIMORE CITY HEALTH DEPARTMENT

69 5821

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) VANCE A. DRUMGOOLE | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 6, 1969
Hour 1:45 A. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
34 BON SECOUR HOSPITAL | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 6, 1969
Hour 1:45 A. M. | |
| 6. SEX
Male | | 7. RACE
Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 19-01 | |
| 9. DATE OF BIRTH
SEPT 9, 1951 | | 10. AGE (In years last birthday) 17
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME
LOUISE ELLISON | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
LOUISE DRUMGOOLE | |
| 19. E9651
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Gunshot wound of abdomen
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
ANTecedent CAUSES | | CAUSE OF DEATH
Gunshot wound of abdomen
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
(C) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
12 N. Mount Street | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) June 5, 1969 2:10 P. m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Subj. shot while attempting to breaking and entering | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Ronald N. Kornblum M.D.
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 6/6/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6/10/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
BALTO NATIONAL | | 24D. LOCATION (City, town, or county) (State)
BALTO MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Robert E. Tabor | |
| 25C. FUNERAL DIRECTOR
Thompson & Hays | | ADDRESS
68 N. G. Mount St | |

Donna

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Doctors Reg # 3415 |
|--|---------------------|---|---|---|
| 69 5822 CERTIFICATE OF DEATH | | | | REG. NO. 69 5822 |
| BIRTH NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Sam F. Mirvis</i> | | 2. DATE AND HOUR OF DEATH
<i>6/9/69</i> <i>10¹⁵ A</i> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>md</i> B. COUNTY <i>27-40</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>5907 Park Heights Ave</i> | | C. CITY OR TOWN
<i>Balto</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
<i>5907 Park Heights Ave</i> | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Oct 23, 1886</i> | 9. AGE (In years last birthday)
<i>82</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>---</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Lith</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 13. FATHER'S NAME
<i>Joseph</i> | | |
| 14. MOTHER'S MAIDEN NAME
<i>Ethel</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | |
| 16. SOCIAL SECURITY NO.
<i>---</i> | | 17. INFORMANT
<i>ms Ethel Gerner</i> | | |
| 18. <i>1944 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Cerebral Corrosion at aneurysm</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>yr</i> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
<i>6/10/69</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>---</i> | | 20A. AUTOPSY? (Yes or No)
<i>No</i> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<i>---</i> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1944</i> 19 to <i>6/9/69</i> 19, that (I) <i>we</i> last saw the deceased alive on <i>6/8/69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<i>Milton Kirsh</i> | | 23B. DATE SIGNED
<i>6/9/69</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>MILTON KIRSH</i> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6/10/69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Han Hanumuck</i> |
| 24D. LOCATION (City, town, or county) (State)
<i>Jerusalem Israel</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 9 1969</i> | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Baker, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Edmond S. Lewis & Son, Inc</i> | | |
| 25D. ADDRESS
<i>9610 Reisterstown Rd</i> | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|------------------|--|---|--|--------------------------------------|--|---|--|--|--|------------------------------|--|--|--|--|--|--|--|
| BIRTH NO. (HERBERT PANCOAST BANGS) | | | | | CERTIFICATE OF DEATH | | | | | REG. NO. 69 5823 | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) HERBERT P. BANGS | | | | | 2. DATE AND HOUR OF DEATH
June 8th 1969 1. Am | | | | | | | | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Church Home & Hospital
35 Baltimore - MD. 21231. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore B. COUNTY Harford
C. CITY OR TOWN BALTIMORE 21209 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 7830 Chelsea Street | | | | | | | | | | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2.16.1897 | | 9. AGE (In years last birthday) 72 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Music Piano Tech. | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | | | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | |
| 13. FATHER'S NAME
ELIJAH L. BANGS. | | | | | 14. MOTHER'S MAIDEN NAME
ALVERTA PANCOAST | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
? Not known | | | | | 16. SOCIAL SECURITY NO.
217-09-1808 | | | | | 17. INFORMANT
Mrs. Margaret H. Bangs (wife) | | | | | ADDRESS
7830 Chelsea St. Ruxton Md. 21204 | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | | ? Murmur Cardiac aortic
OR Pulm. Embolism
with Hemaline Ventricular Cardiac
Record reop. in the lung
Carcinoma Large bowel
Patient has prev. cardiac arrhythmia | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr.
Approx 10 hrs
18 months | | | | |
| | | | | | | | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | |
| | | | | | | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | |
| | | | | | | | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | |
| 19A. DATE OF OPERATION
6.3.69 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Record. in the lung L.L.L. | | | | | 20A. AUTOPSY? (Yes or No)
No | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5.16.69 19 69 to 6.4.1969 19 69 that (I) (we) last saw the deceased alive on 5-6-69 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | 23A. SIGNATURE
Prabir K. Bose M.D. | | | | | 23B. DATE SIGNED
6.7.69 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
PRABIR K. BOSE. M.D. | | | | | 23D. ADDRESS
CHURCH HOME AND HOSPITAL
BALTIMORE MD 21231. | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | 24B. DATE
June 10.1969 | | | | | 24C. NAME OF CEMETERY or CREMATORY
Gunpowder Friends Meeting Cem. | | | | | 24D. LOCATION (City, town, or county) (State)
Sparks Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | | | | 25B. NAME OF REGISTRAR
John E. Taber, M.D. | | | | | 25C. FUNERAL DIRECTOR
HENRY SANDER & SONS, INC. | | | | | ADDRESS
Baltimore Md. | | | | |



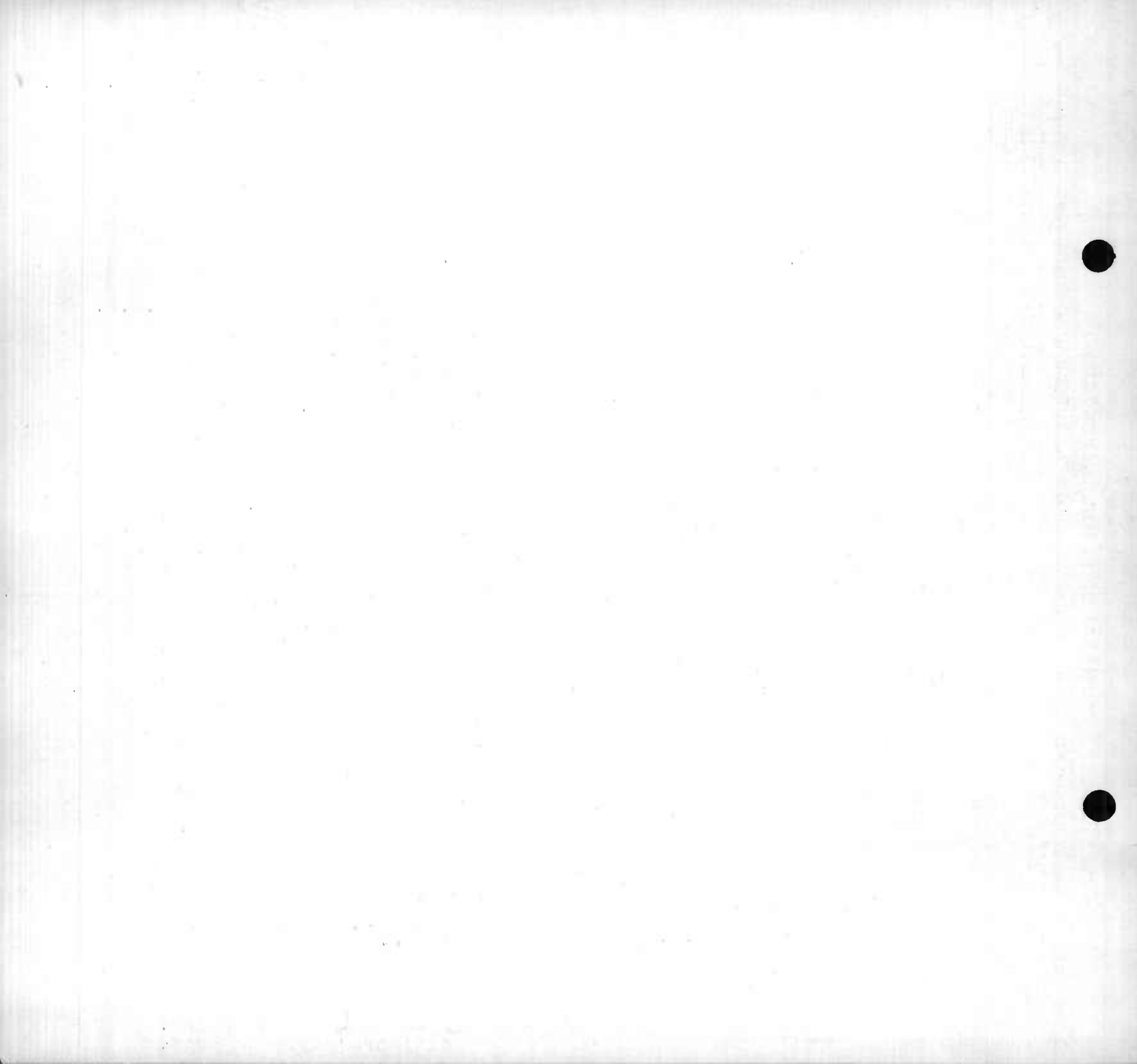
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5824 CERTIFICATE OF DEATH

REG. NO. 69 5824

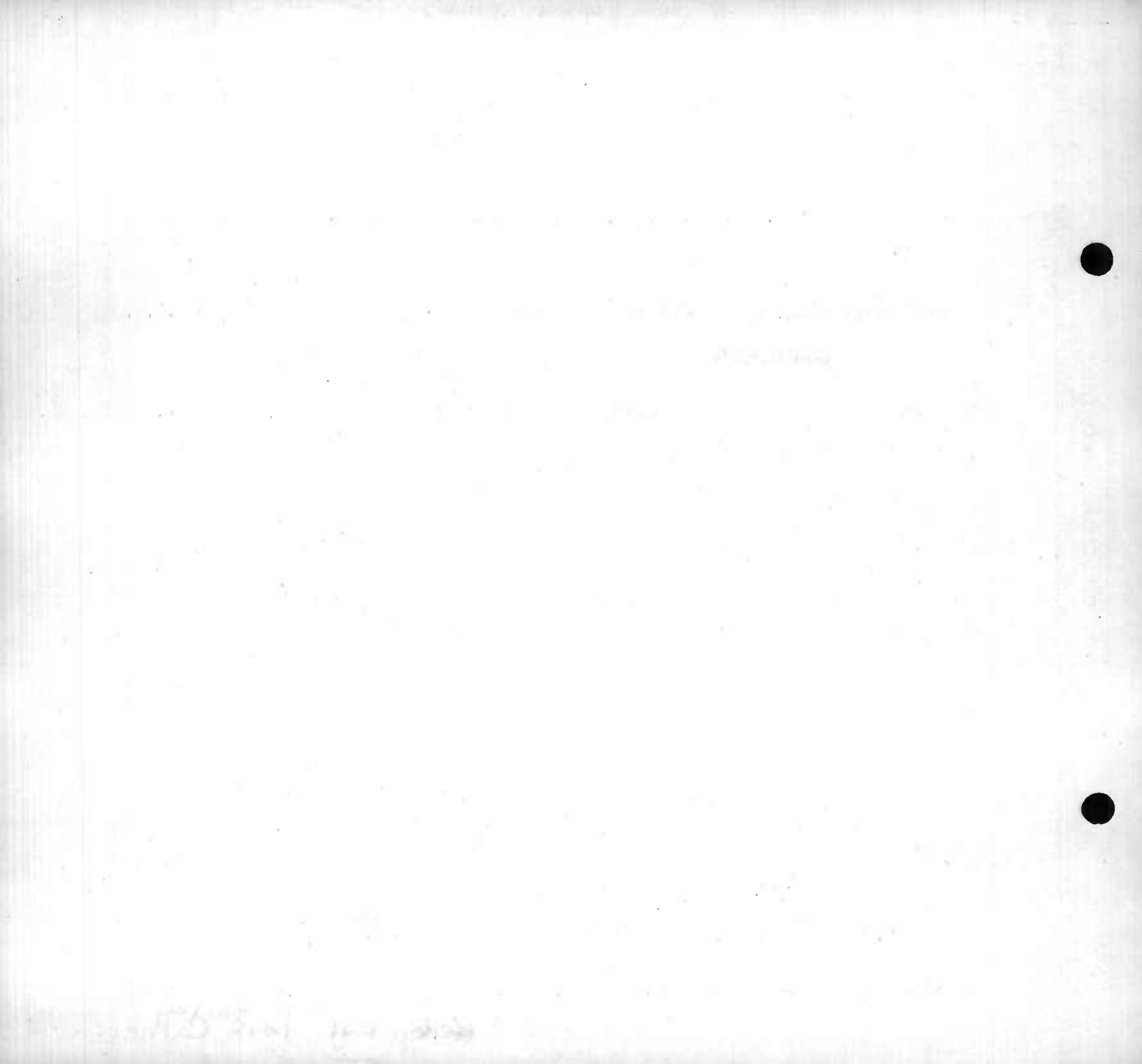
| | | | | | |
|---|------------------------|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | MARY CATHERINE PESSAGNO | | JUNE 5, 1969 9:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | |
| 00 2108 Harford Road | | | | Maryland | |
| | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | | | Baltimore 21218 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | |
| | | | | 2108 Harford Road | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Oct. 30, 1890 | 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | At Home | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Michael Beierschmidt | | | U.S.A. | | |
| 14. MOTHER'S MAIDEN NAME | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| Christina ? | | | NO | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| 218 32 2534 | | | Mrs Dorothy E. Manuel 2108 Harford | | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | Sudden | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/17 1965 to 6/5 1969, that (I) (we) last saw the deceased alive on 6/5 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Joseph S. Blum M.D. | | | | 6/6/69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Joseph Blum M.D. | | | | 1115 N. Calvert Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 6/9/69 | Most Holy Redeemer | Baltimore Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUN 9 1969 | Robert E. Taylor, M.D. | Henry Sander & Sons Inc. | | Baltimore Maryland 21213 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|----------------------------|--|------------------------------------|---|--|---|-----------------------------------|--|
| 69 5825 CERTIFICATE OF DEATH | | | | | REG. NO. 69 5825 | | | | |
| BIRTH NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>GEORGE GARRISON</u> | | | | | 6/3/69 1 6 05 P M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>14-03</u> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>31 BALTIMORE CITY HOSPITALS</u>
<u>4940 EASTERN AVE., BALTIMORE, MD. #21224</u> | | | | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH
<u>1-28-15</u> | | 9. AGE (In years last birthday)
<u>54</u> | | If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Longshoreman</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Retired - Dis.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>JOHNNY GARRISON</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>MARTHA SISCO</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | | | 16. SOCIAL SECURITY NO.
<u>216-07-9291</u> | | 17. INFORMANT
<u>BCH; RECORDS 4940 EASTERN AVE. BALTO. MD.</u> | | ADDRESS
<u>#21224</u> |
| 18. <u>203 X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | (A) IMMEDIATE CAUSE <u>CARDIO-RESPIRATORY ARREST</u> <u>10 MIN.</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>ACUTE RENAL FAILURE</u> <u>2 WKS</u>
(C) <u>MULTIPLE MYELOMA</u> <u>? 1 YR.</u> | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>YES</u> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/30</u> 19 <u>69</u> to <u>6/3</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/3</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>V. Valdmanis, MD</u> | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<u>6/3/69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>V. VALDMANIS, MD.</u> | | | | | 23D. ADDRESS
<u>BALTIMORE CITY HOSPITALS</u>
<u>4940 EASTERN AVE., BALTIMORE, MARYLAND 21224</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | | 24D. LOCATION (City, town, or county) (State) | | |
| <u>Burial</u> | | <u>6-7-69</u> | | <u>MT. AUBURN CEM.</u> | | | <u>BALTO. MD.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | | ADDRESS | | |
| <u>JUN 9 1969</u> | | <u>Edgar E. Bailey, MD</u> | | <u>B. R. Bailey</u> | | | <u>1348 Calhoun St.</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5826</u> |
|---|--|--|--|---|
| BIRTH NO. <u>69 5826</u> | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>BARROLL, ANNIE E.</u> | | 2. DATE AND HOUR OF DEATH
<u>JUNE 3, 1969 8 05 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

<u>425 SINAI HOSPITAL OF BALTIMORE</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>16-05</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>SINAI HOSPITAL OF BALTIMORE</u> | | C. CITY OR TOWN
<u>Balto.</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER
<u>2535 Calverton Hgts. Ave.</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>DOROTHY HARMONY</u> |
| 18. <u>4-10-9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>ACUTE MYOCARDIAL INF.</u>
<u>A.S.C.V.D</u>
(B) _____
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Seconds</u> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | <u>ANASARCA W. C.H.F</u> | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> 19 <u>69</u> to <u>6/3</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/3</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>J. Laeventman M.D.</u> | | 23B. DATE SIGNED
<u>6/3/69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>JAIME LAVENTMAN M.D.</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>6-7-69</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Mt. Auburn Cem.</u> |
| 24D. LOCATION (City, town, or county)
<u>BALTO. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 9 1969</u> | | |
| 25B. NAME OF REGISTRAR
<u>Robert A. Bailey, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>D.R. BAILEY</u> | | |
| 25D. ADDRESS
<u>1348 N. CALHOUN ST.</u> | | | | |

69 5827

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5827

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HARRY HOOPER

2. DATE
OF
DEATHKnown ☒
Estimated ☐Month
Day
YearDay
Year
HourYear
Hour

Hour

11:10 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEADMonth
Day
YearDay
Year
HourYear
Hour

Hour

11:10 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

14-02

6. SEX

Male

7. RACE

Colored

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1-1-00

10. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1534 Druid Hill Ave.

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Arron Hooper

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Clementine Thompson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

705109102

18. INFORMANT

Wilbert Hooper

ADDRESS

928 Wicklow Rd.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRI-
BUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 1, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-6-69

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Balto. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Kelson F.H.

V.R. Bailey

1348 Calhoun St.

CH-1-

1/11/14

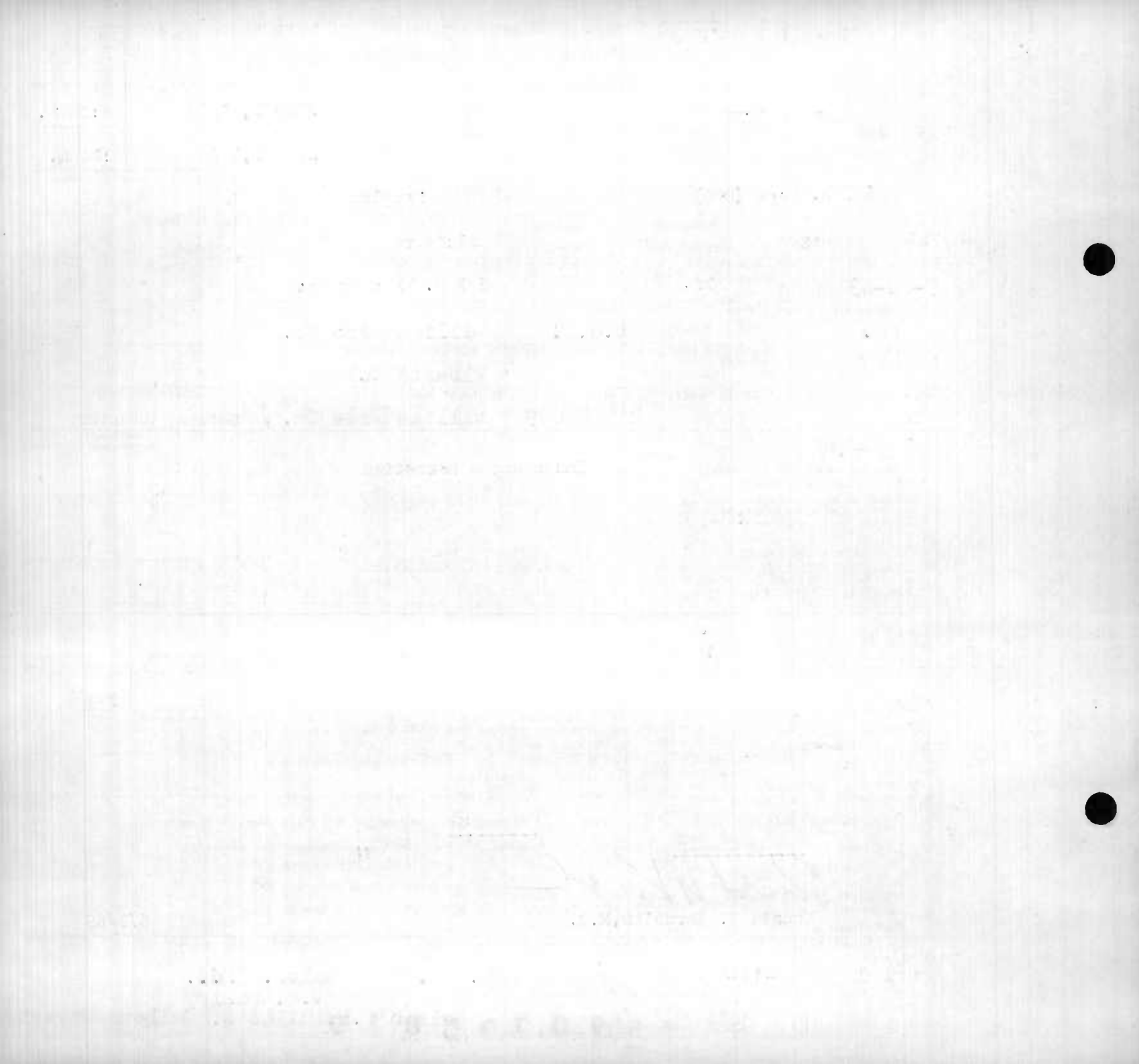
WALSH & COMPANY

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
ROGERS WISE | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 7, 1969
Hour 4:24 A. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
607 N. Paca (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 7, 1969
Hour 4:24 A. | |
| 6. SEX
Male | | 7. RACE
Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
9-23-43 | | 10. AGE (In years last birthday) 25
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 17. SOCIAL SECURITY NO.
219402099 | |
| 15. MOTHER'S MAIDEN NAME
Alberta Tolend | | 18. INFORMANT
William Wise Sr. | |
| 19. 304.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Intravenous narcotism
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | ADDRESS
same father | |
| MEDICAL CERTIFICATION | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) (Minute) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-11-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Arbutus Mem. Pk. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
V.R. Bailey | | 25D. ADDRESS
1348 N. Calhoun Street | |



FUNERAL DIRECTOR: IMPORTANT

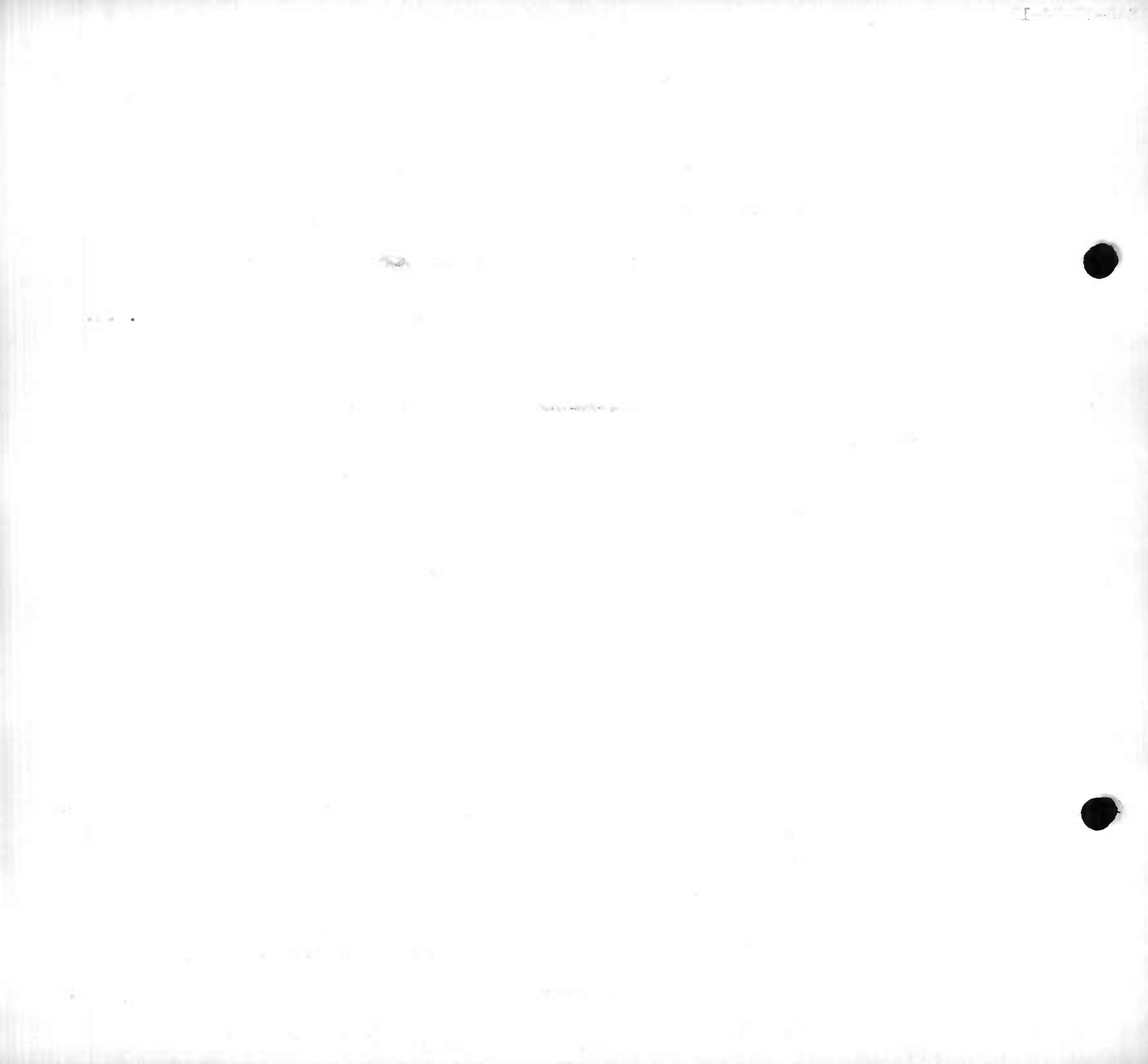
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-300 69 5829 BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5829 | |
|---|--|---|---|--|---|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>MARY BOYD</u> | | | 2. DATE AND HOUR OF DEATH
<u>6/6/69</u> <u>3:30A</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>31</u> <u>Baltimore City Hospitals</u>
<u>4940 Eastern Avenue</u>
<u>Baltimore, Maryland</u> <u>21224</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>27-33</u> | | |
| 5. SEX <u>Female</u> | | | 6. RACE <u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>3-17-1894</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | | 9. AGE (In years last birthday) <u>75</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Henry Hill</u> | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Lincoln</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | 16. SOCIAL SECURITY NO. <u>213-58-4727</u> | | 17. INFORMANT ADDRESS
<u>Records: BCH-4940 Eastern Avenue</u> <u>21224</u> |
| 18. <u>412.41</u> CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 wks</u>
<u>2 wks</u>
<u>years</u> |
| 19A. DATE OF OPERATION <u>6/5</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> 19 <u>69</u> to <u>6/6</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/6</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Robert A. Rosenbaum, M.D.</u> | | | | 23B. DATE SIGNED <u>6/6/69</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Robert A. Rosenbaum</u> | | | | 23D. ADDRESS <u>Baltimore City Hospitals</u>
<u>4940 Eastern Avenue, Baltimore, Maryland</u> <u>21224</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>6-11-69</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Church Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Middlesex County, Va.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1969</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>V.R. Bailey</u> ADDRESS <u>1248 N. Calhoun Street</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 5830

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) ELEN FITZ HUGH | | 2. DATE AND HOUR OF DEATH
6/8/69 | | P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY 16-08 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
722 EDGEMOOD ST. | | C. CITY OR TOWN
BALTO. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
FEMALE | | 6. RACE
NEGROID | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
3-2-89 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (in years last birthday)
80 | | 11. BIRTHPLACE (State or foreign country)
16-08 | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME
CORA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

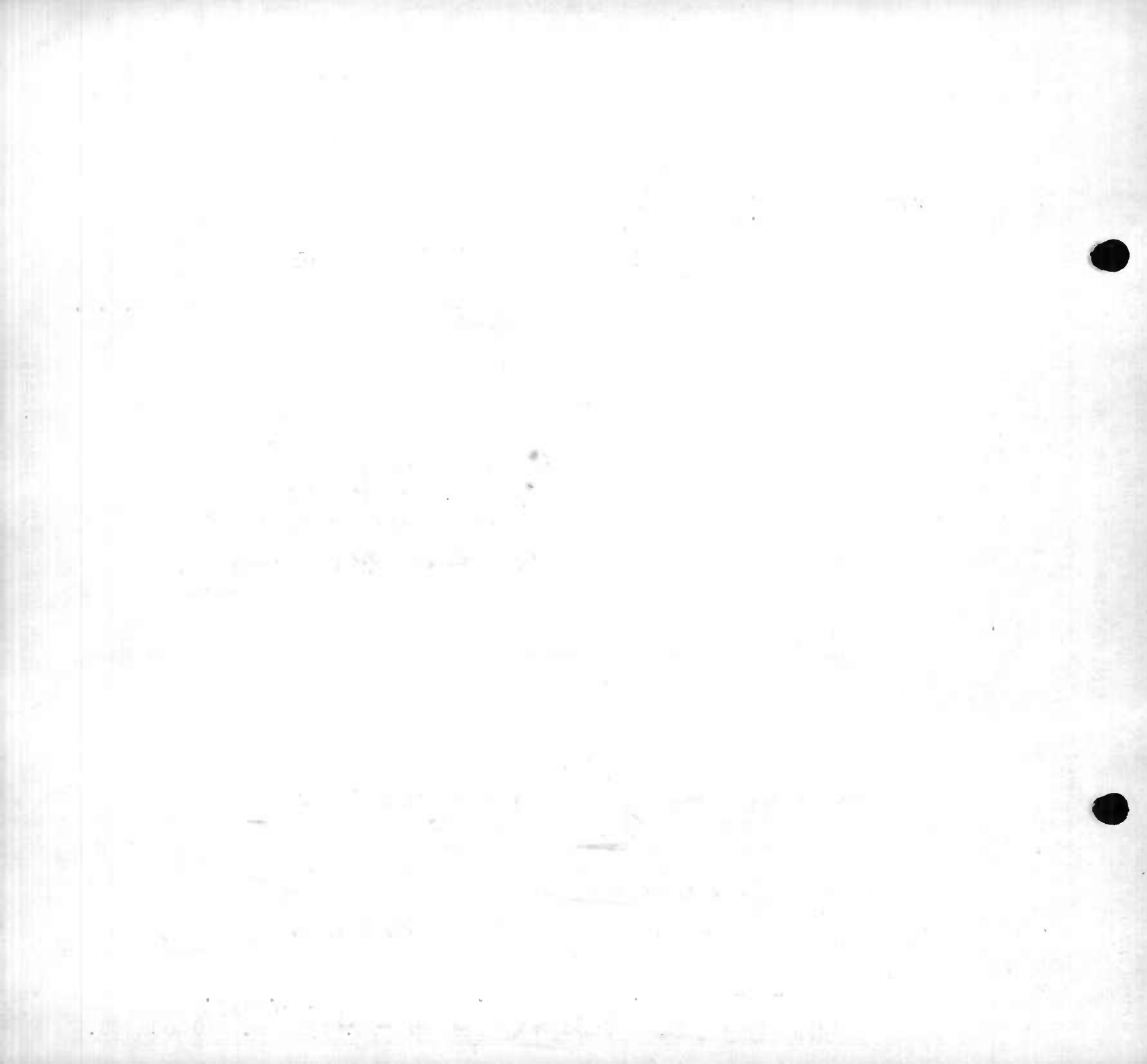
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
AS HD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years | |
| | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 68 to June 19 69 that (I) (we) last saw the deceased alive on June 19 69 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
M. Susan Bollinger MD | | | | 23B. DATE SIGNED
6/8/69 | | | |
| 23C. PHYSICIAN'S NAME (Type)
M. SUSAN BOLLINGER MD | | 23D. ADDRESS
MD | | 23E. PHYSICIAN'S DEGREE
MD | | 23F. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-12-69 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem | | 24D. LOCATION (City, town, or county) (State)
BALTO. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
0. H. BAILEY | | ADDRESS
1348 CALHOUN ST. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 5831 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 69 5831 | |
|---|----------------------|--|---------------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Isadore Moses WILSON | | | | 2. DATE AND HOUR OF DEATH 6/7/69 2:50 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 17-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Century Home, Inc 102 N. Paca St Balto. Md 21201 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) 403 Oxford Ct #1 | | | | | | | |
| 5. SEX male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single | 8. DATE OF BIRTH 7/31/05 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Moses Wilson | | | | 14. MOTHER'S MAIDEN NAME Fannie Nichols | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 212 346142 | | 17. INFORMANT Marie Lewis | | ADDRESS 2808 Auchentoroly Ter. | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Cardio-respiratory failure | | | |
| | | | | (B) Congestive Heart Failure | | | |
| | | | | (C) Arteriosclerotic CVD | | | |
| | | | | (D) Cerebral Thrombosis | | | |
| | | | | (E) Parkinson Disease | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 26 19 69 to June 7 19 69 , that (I) (we) last saw the deceased alive on June 7 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE William Appleford M.D. | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) William Appleford | | | | 23D. ADDRESS 6615 Neustetman Rd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 6-10-69 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 9 1969 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR V. A. Bailey | | ADDRESS 1348 N. Calhoun St. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5832

BIRTH NO.

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print) LAURAL SLATTERY (SMITH) | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 7, 1969
Hour 10:50 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
3022 E. Fayette Street (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 7, 1969
Hour 10:50 P.M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 6-01 | | | |
| 6. SEX
Female | 7. RACE
White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH
8-26-1924 | | 10. AGE (In years lost birthday) 44
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WAITRESS | | 14B. KIND OF BUSINESS OR INDUSTRY
RESTAURANT | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)
No | | 17. SOCIAL SECURITY NO.
579 22 5123 | |
| 18. INFORMANT
Mr. Willie W. Smith - 3022 E. Fayette St. | | ADDRESS | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Fatty Metamorphosis of the Liver with | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
complicating bronchopneumonia | | (A) IMMEDIATE CAUSE
TOXIC OPAC X CIRCULATORY FAILURE
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Russell S. Fisher M.D.
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.
DATE SIGNED 6/8/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-11-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
MT. HOREB CEM. | | 24D. LOCATION (City, town, or county) (State)
ORANGE, VA. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Robert E. Gabe, M.D. | |
| 25C. FUNERAL DIRECTOR
Shelley Fisher - 2334 Jefferson St. | | ADDRESS | |

(over)

GREENMAN SECTION

U.S.A.

VIRGINIA

CONCRETE

TESTING

SECTION

BY DATE 11-11-64

NO

Greenman

Greenman

11-11-64

CONCRETE

11-11-64

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

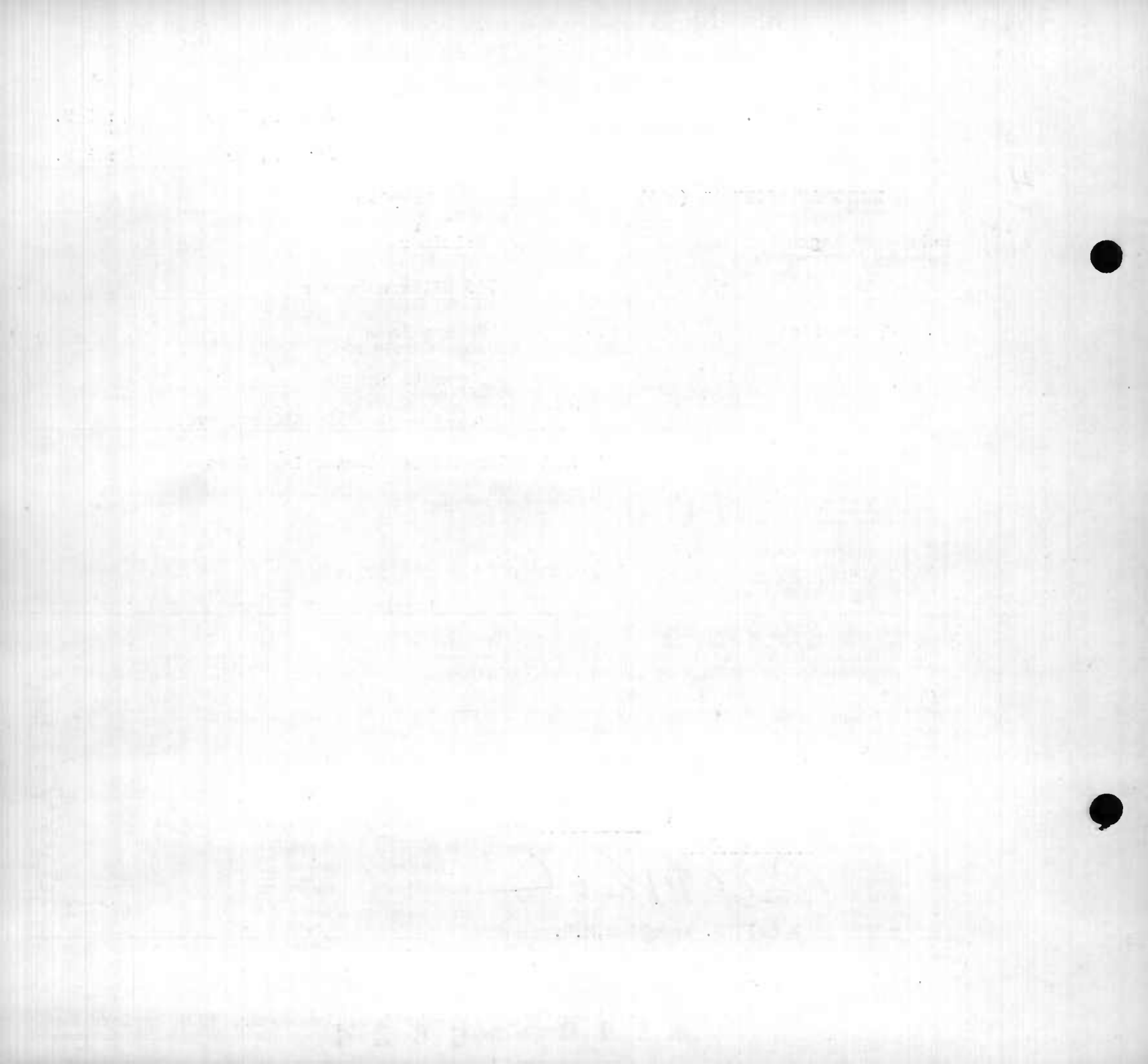
REG. NO.

BIRTH NO.

| | | | |
|--|-------------------------|--|---|
| 1. NAME OF DECEASED
(Type or Print)
BECKETT L. BROWN | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 5, 1969 9:43 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
LUTHERAN HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 5, 1969 9:43 P. M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 16-05 | | | |
| 6. SEX
Male | 7. RACE
Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN
Baltimore |
| 9. DATE OF BIRTH
12-7-04 | | 10. AGE (In years lost birthday)
64 | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country)
South Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | E. STREET AND NUMBER
715 Wilbron Avenue |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Steel Work | | 14B. KIND OF BUSINESS OR INDUSTRY
fannie Shaw | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO. | 15. MOTHER'S MAIDEN NAME
Edward Brown 5559 Elderon Ave. |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH
Arteriosclerotic cardiovascular disease | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Ronald N. Kornblum
EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED
6/6/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-11-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Marshall W. Jones, Jr. | |
| 25C. FUNERAL DIRECTOR
Marshall W. Jones, Jr. | | 25D. ADDRESS
1735 Harford Ave. | |



69 5834 CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>WILLIAM M. HARDWICK</i> | | 2. DATE AND HOUR OF DEATH
<i>6-5-69</i> <i>2:45 PM.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>17-02</i> | | C. CITY OR TOWN <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>45 Good Samaritan Hospital</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
<i>Male</i> | | 6. RACE
<i>Negro</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Laborer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
<i>3-9-1906</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Georgia</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 9. AGE (In years lost birthday)
<i>63</i> | |
| 13. FATHER'S NAME
<i>Gip Hardrick</i> | | 14. MOTHER'S MAIDEN NAME
<i>Martha ?</i> | | 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | |
| 16. SOCIAL SECURITY NO.
<i>212-10-1561-A</i> | | 17. INFORMANT
<i>Mary Hardrick</i> | | ADDRESS
<i>468 Tubman Court</i> | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Pulmonary embolus</i>
(B) <i>Cerebral vascular accident</i>
(C) <i>Atherosclerosis Cardiovascular disease</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 hr</i>
<i>3/6/69</i>
<i>-</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<i>Suspected but not proven - occult carcinoma</i> | | 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>3-7</i> <i>19 69</i> to <i>6-5</i> <i>19 69</i> , that (I) (we) last saw the deceased alive on <i>6-5</i> <i>1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE
<i>David W. Zuffman md</i> | | 23B. DATE SIGNED
<i>6-5-69</i> | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS | | 23E. DEGREE | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | |
| 24B. DATE
<i>6-10-69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Mt. Calvary Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>A.A. Co, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 9 1969</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, MD</i> | | 25C. FUNERAL DIRECTOR
<i>Marshall W. Jones, Jr. 1735 Harford Ave</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5835

CERTIFICATE OF DEATH

REG. NO.

69 5835

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Alstine C. Bryant

2. DATE AND HOUR OF DEATH

6-5-69

1:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2911 Pinewood Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2911 Pinewood Ave.

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2-27-1895

9. AGE (In years last birthday)

74

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret'd Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Sealtest Dairy

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Caleb

Bryant

14. MOTHER'S MAIDEN NAME

Etta Lusby

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War 1

16. SOCIAL SECURITY NO.

216-10-8597

17. INFORMANT

Florence E. Bryant

ADDRESS

Same

18. ~~7-2-69~~ I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Cardiac arrest

(B) DUE TO, OR AS A CONSEQUENCE OF:

Congestive heart failure

(C) DUE TO, OR AS A CONSEQUENCE OF:

Severe pulmonary emphysema

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Sudden

Several months

Several years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the undersigned) attended the deceased from July 26, 19 61 to June 3, 19 69

that (I) (we) last saw the deceased alive on June 3, 19 69 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

S. J. Liu M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

6/6/69

23C. PHYSICIAN'S NAME (Type)

S. J. Liu, M. D.

DEGREE

23D. ADDRESS

5300 Harford Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-7-69

24C. NAME OF CEMETERY or CREMATORY

Moreland Mem. Park

24D. LOCATION

Balto. Co.

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1969

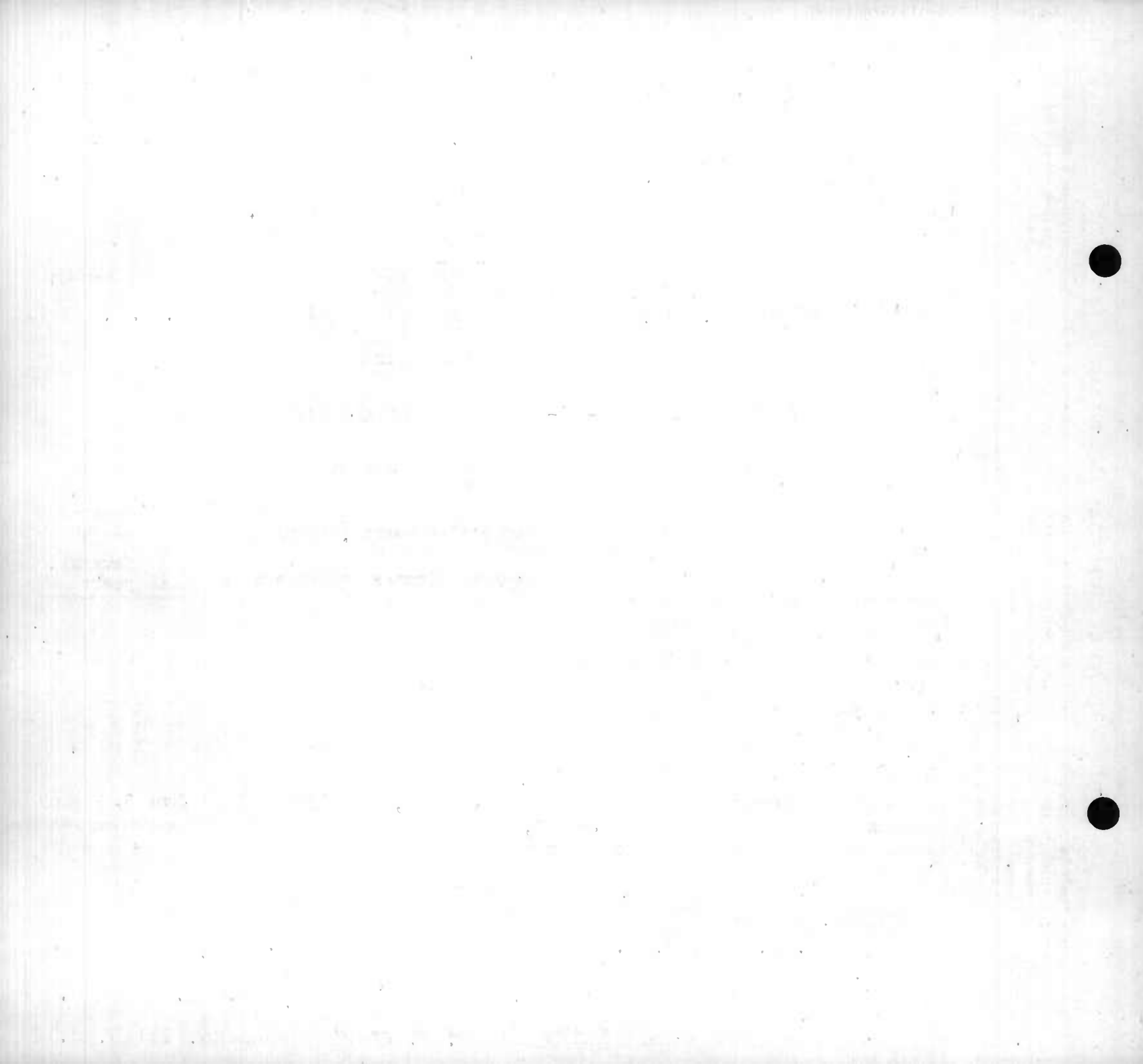
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

H. W. Jenkins Sons Co. Balto. Md. 12

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5836
REG. NO.

BIRTH NO.

| | | | | |
|---|-------------------------|---|--|--|
| 1. NAME OF DECEASED
(Type or Print) JOSEPH / WILSON | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 7, 1969 | | Hour 11:00 A.M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
39 PROVIDENT HOSPITAL | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 7, 1969 | | Hour 11:00 A.M. |
| 5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland B. COUNTY 27-78 | | | | |
| 6. SEX
Male | 7. RACE
White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN
Baltimore | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH
1/1/1924 | | 10. AGE (In years lost birthday)
45 | E. STREET AND NUMBER
1030 St. Dunstons Road | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | 13. FATHER'S NAME
Joseph Wilson | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
President-Restaurant | | 14B. KIND OF BUSINESS OR INDUSTRY
Wilson's Restr. Inc. | 15. MOTHER'S MAIDEN NAME
Lillian Oliver | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WWII | | 17. SOCIAL SECURITY NO.
219-18-8050 | 18. INFORMANT
Mrs. Elnora M. Wilson ADDRESS (Same) | |
| 19. E966X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH
Multiple stab wounds of (left) chest
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | |
| 20A. DATE OF OPERATION
21 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Restaurant | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
(Wilson Restaurant-1601 W. North Avenue |
| 22D. TIME OF INJURY (Approx.)
June 7, 1969 | | 22E. INJURY OCCURRED
WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 22F. HOW DID INJURY OCCUR?
Subject found lying in hallway | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE Russell S. Fisher M.D.
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>

DATE SIGNED 6/8/69 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Entombment | | 24B. DATE
6/10/69 | 24C. NAME of CEMETERY or CREMATORY
Lorraine Park Mausoleum | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road, Balto. 12, Md. |

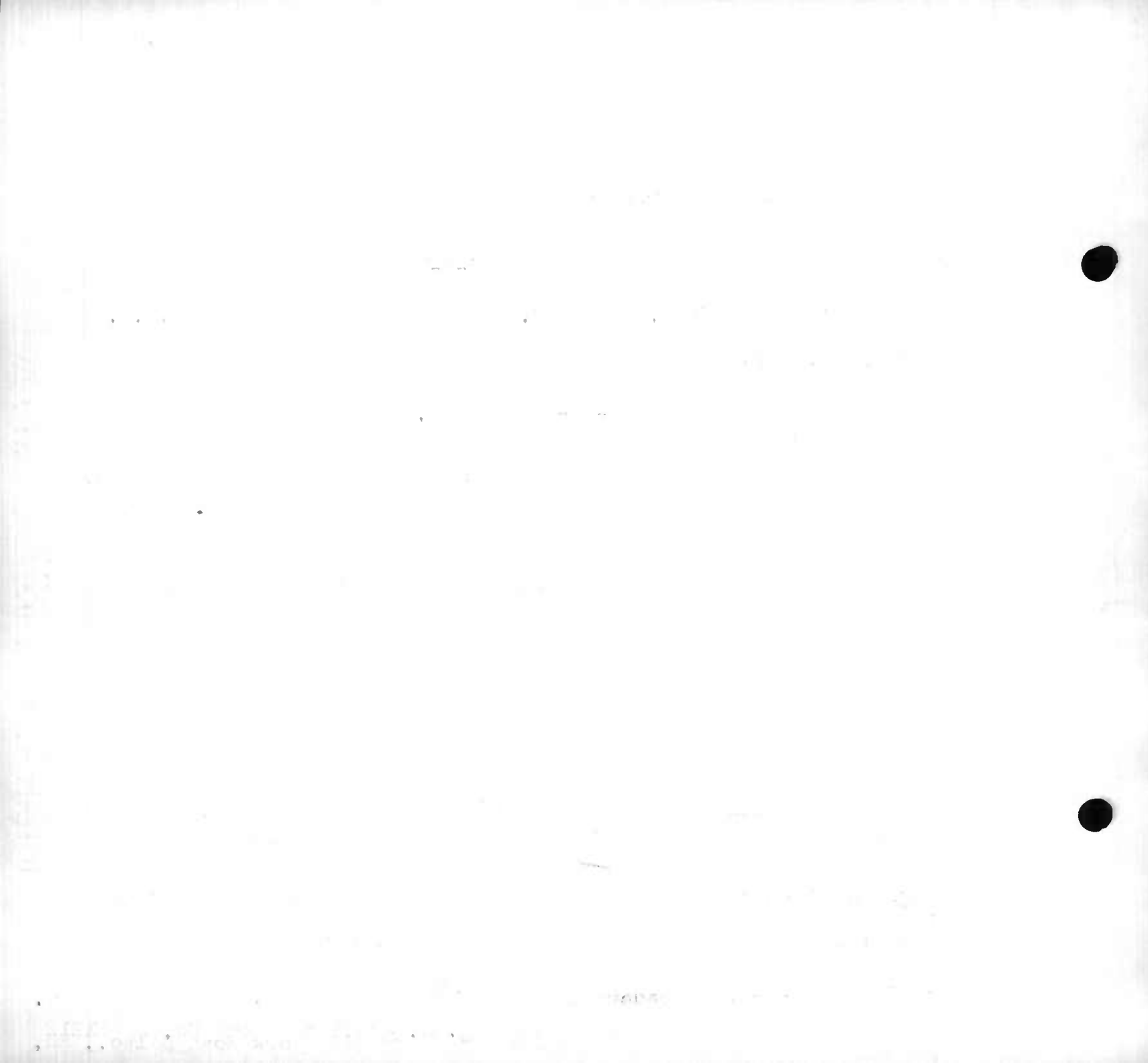
Grand Master

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>2-2-02</u>
<u>69 5837</u> |
|---|------------------------------|---|-------------------------------------|--|
| BIRTH NO. <u>10-520</u> | | 69 5837 | | |
| 1. NAME OF DECEASED
(Type or Print) <u>EDWARD OWENS</u> | | 2. DATE AND HOUR OF DEATH
<u>4/6/69</u> <u>115 P</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>The Johns Hopkins Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>26-08</u> | | |
| | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
<u>255 S. Highland Avenue</u> | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2-3-1902</u> | 9. AGE (In years last birthday) <u>67</u>
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Steel Worker</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Beth. Steel Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> |
| | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>Edward A. Owens</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lula Blades</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-07-4684</u> | | 17. INFORMANT
<u>Mrs. Edward Owens</u> |
| | | | | ADDRESS
<u>Same</u> |
| 18. <u>492X</u>
CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Empty stomach & pulmonary insufficiency</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>11</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>Insufficient</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>7 years</u> |
| | | | | <u>1 month</u> |
| MEDICAL CERTIFICATION | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/7/69</u> 19 to <u>6/6/69</u> 19
that (I) (we) lost saw the deceased alive on <u>4/4/69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Jerome L. Rubin M.D.</u> | | | | 23B. DATE SIGNED
<u>6/6/69</u> |
| 23C. PHYSICIAN'S NAME (Type)
<u>JEROME RUBIN M.D.</u> | | 23D. ADDRESS
<u>JOHNS HOPKINS HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>6-9-1969</u> | 24C. NAME of CEMETERY or CREMATORY
<u>Meadowridge Memorial Park</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Dorsey, Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 9 1969</u> | | 25B. NAME OF REGISTRAR
<u>Jerome L. Rubin M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>H. B. Jenkins & Sons Co.</u> |
| | | | | ADDRESS
<u>1905 York Road Balto., Md. 21212</u> |



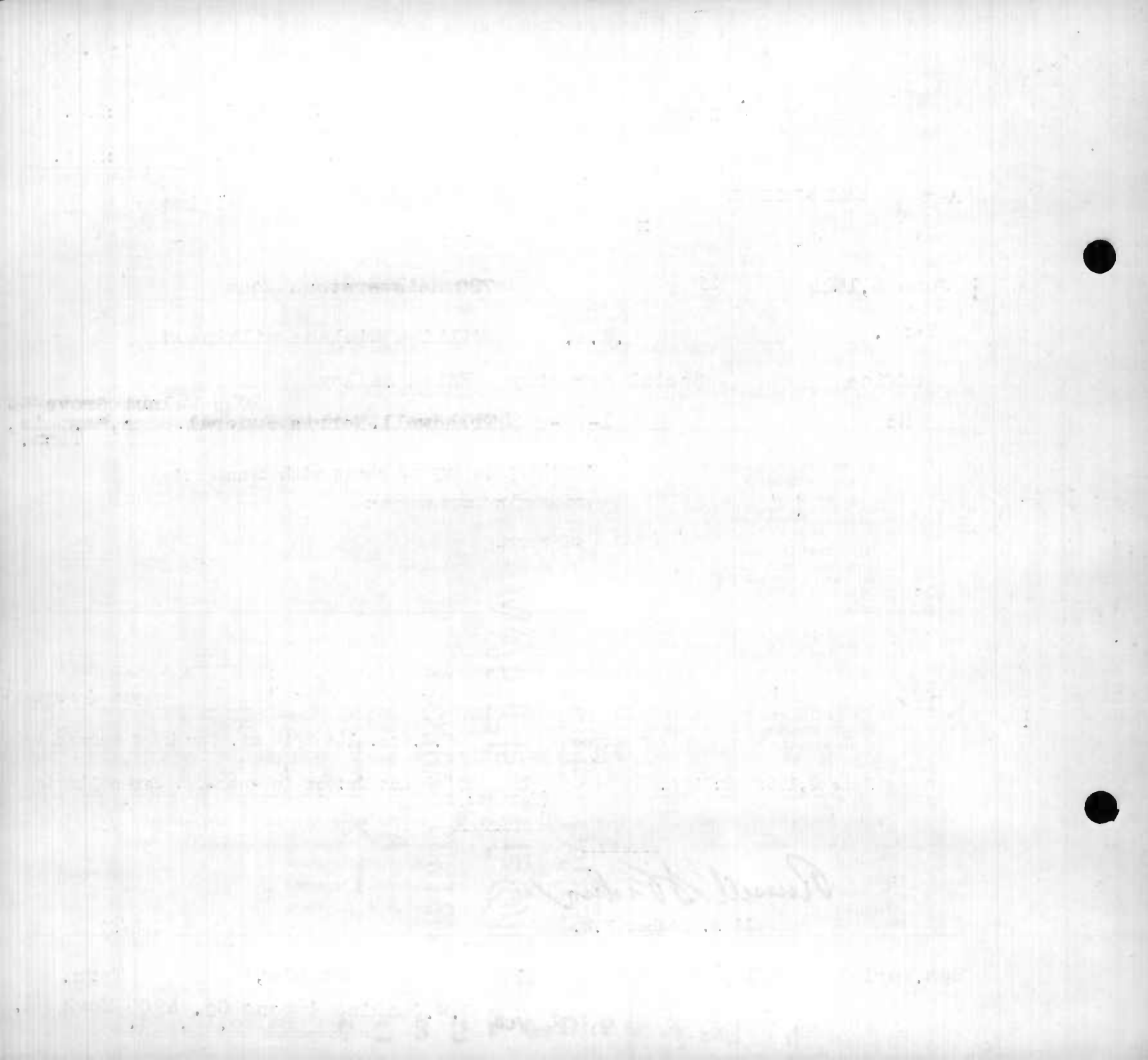
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5838

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) B. ERNEST / WILKINSON | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 8, 1969 Hour 4:55A. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
42 SINAI HOSPITAL | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 8, 1969 Hour 4:55 A. M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
June 6, 1944 | | 10. AGE (In years lost birthday) 25 | |
| 11. BIRTHPLACE (State or foreign country)
Tenn. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Office | | 14B. KIND OF BUSINESS OR INDUSTRY
Social Security | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO.
411-70-0024 | |
| 18. INFORMANT
Edith Bailey | | 19. ADDRESS
2944 Walnut Grove Rd | |
| 20. CAUSE OF DEATH
Crushing injury of chest with transection of aorta | | 21. APPROXIMATE TIME BETWEEN ONSET AND DEATH
15 min. | |
| 22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | |
| 24A. DATE OF OPERATION
6/10/69 | | 24B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 25A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
<input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 25B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | |
| 26. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) June 8, 1969 2:10 A.M. | | 27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 28. HOW DID INJURY OCCUR?
Subject driver in auto-two car collision | | 29. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
U.S. Rte. 140 2/10 mi. North of Kenmar Avenue | |
| 30. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 31. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| 32. ACTUAL SIGNATURE Russell S. Fisher M.D. | | 33. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 34. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | 35. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 36. DATE REC'D BY HEALTH DEPT.
6/10/69 | | 37. NAME OF REGISTRAR
H.W. Jenkins & Sons Co. | |
| 38. DATE OF BURIAL CREMATION, REMOVAL (Specify)
Rem. Burial | | 39. DATE OF BURIAL CREMATION, REMOVAL (Specify)
6/10/69 | |
| 40. NAME OF CEMETERY or CREMATORY
Forest Hill | | 41. LOCATION (City, town, or county) (State)
Memphis, Tenn. | |
| 42. DATE REC'D BY HEALTH DEPT.
6/10/69 | | 43. NAME OF REGISTRAR
H.W. Jenkins & Sons Co. | |
| 44. DATE OF BURIAL CREMATION, REMOVAL (Specify)
Rem. Burial | | 45. DATE OF BURIAL CREMATION, REMOVAL (Specify)
6/10/69 | |
| 46. NAME OF CEMETERY or CREMATORY
Forest Hill | | 47. LOCATION (City, town, or county) (State)
Memphis, Tenn. | |



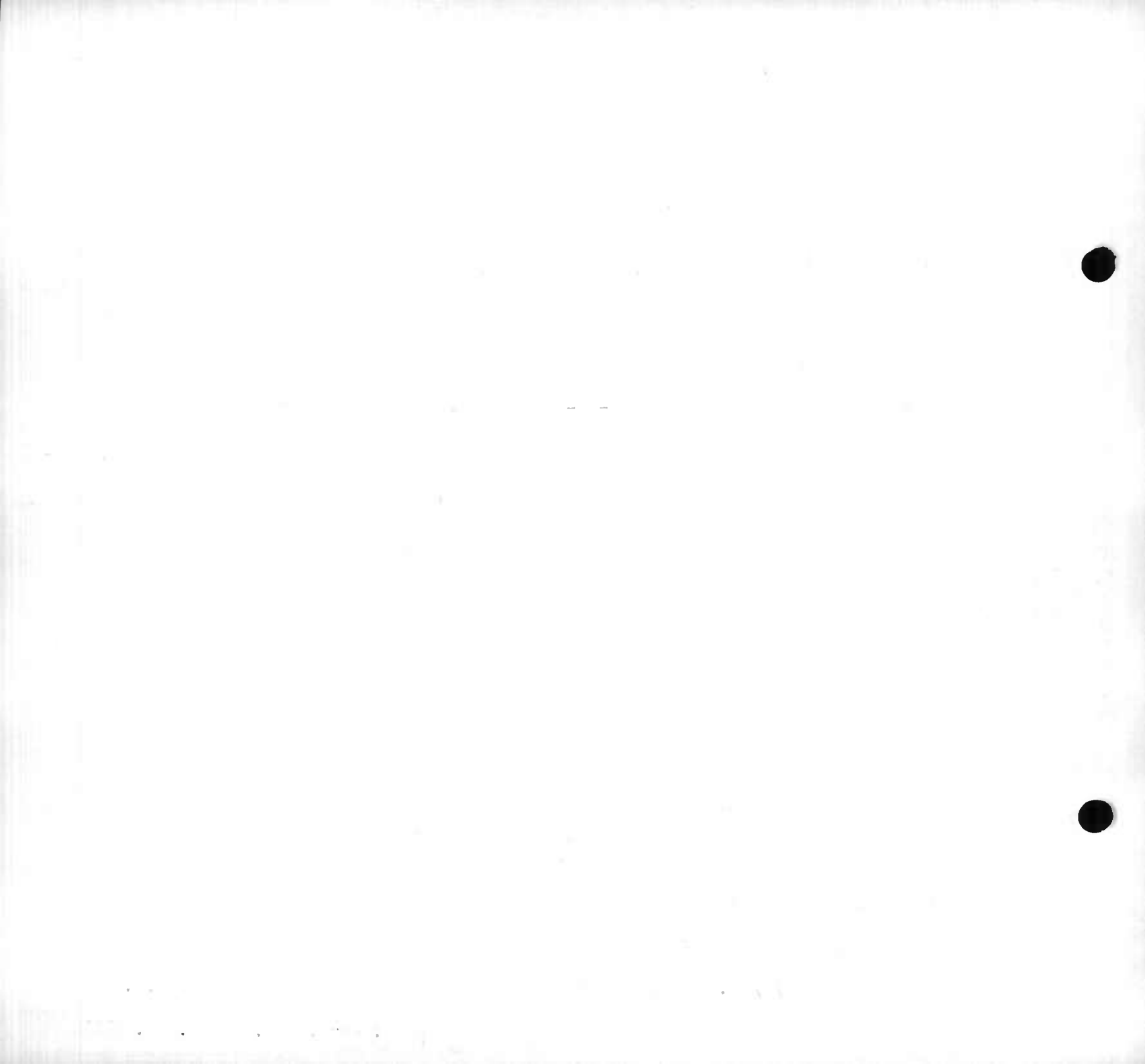
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 00 5839 | |
|--|------------------------------------|--|--|--|---|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED
(Type or Print) Katharyn E. LeFaivre</p> </div> <div> <p>2. DATE AND HOUR OF DEATH
June 8, 1969 5¹⁵ A M.</p> </div> </div> | | | | | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>1015 Woodbourne Ave.</p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Md. B. COUNTY 27-10</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 1015 Woodbourne Ave.</p> | | |
| <p>5. SEX
F</p> | <p>6. RACE
W</p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH
3/9/1904</p> | <p>9. AGE (In years last birthday)
65</p> | <p>If Under 1 Yr. Months: Days: Hours: Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY
Own Home</p> | | <p>11. BIRTHPLACE (State or foreign country)
Baltimore, Md.</p> | |
| <p>13. FATHER'S NAME
Charles E. Murphy</p> | | | <p>14. MOTHER'S MAIDEN NAME
Elizabeth Jacobs</p> | | |
| <p>15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No</p> | | <p>16. SOCIAL SECURITY NO.</p> | | <p>17. INFORMANT
Louis G. LeFaivre, Sr.</p> | |
| | | | | <p>ADDRESS
(Same)</p> | |
| <p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
metastatic CA-Vereteprae-long. 6 mos.</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
CACINOMA Right Kidney</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:
1968</p> <p>(C) _____</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1968</p> | | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> | | | | | |
| <p>19A. DATE OF OPERATION
6-7-68</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No)
No</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)</p> | | <p>21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (1) (this hospital) attended the deceased from <u>12-18-68</u> to <u>6/8/68</u>, that (2) (we) last saw the deceased alive on <u>6-7-68</u> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE
<i>Anthony F. Carozza</i></p> | | | | <p>23B. DATE SIGNED
6-9-69.</p> | |
| <p>23C. PHYSICIAN'S NAME (Type)
Dr. Anthony F. Carozza</p> | | | | <p>23D. ADDRESS
5217 York Road</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)
Burial</p> | | <p>24B. DATE
6/11/69</p> | | <p>24C. NAME of CEMETERY or CREMATORY
Dulaney Valley Mem. Grds.</p> | |
| | | | | <p>24D. LOCATION (City, town, or county) (State)
Timonium, Md.</p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT.</p> | | <p>25B. NAME OF REGISTRAR
Robert E. Barber, M.D.</p> | | <p>25C. FUNERAL DIRECTOR
H. J. Jenkins & Sons Co.</p> | |
| | | | | <p>ADDRESS
4905 York Rd. Balto. 12, Md.</p> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | 69 5840 | |
|---|---------------------|---|--|--|--|--|--|
| BIRTH NO. 69 5840 | | | | CERTIFICATE OF DEATH | | REG. NO. 69 5840 | |
| 1. NAME OF DECEASED
(Type or Print) <u>MARGARET JOHNSON</u> | | | | 2. DATE AND HOUR OF DEATH
<u>6/5/69 1 9³⁰ P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Johns Hopkins Hospital</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>33</u> | | A. STATE
<u>MARYLAND</u> | | B. COUNTY
<u>Baltimore</u> | |
| | | | | C. CITY OR TOWN
<u>BALTO</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<u>1230 PRIMROSE AVE</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>2-03-85</u> | 9. AGE (in years last birthday)
<u>84</u> | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>New Jersey</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | 13. FATHER'S NAME
<u>FREDERICK KIRCHNER</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>ANNIE Rice</u> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>151-05-5942D</u> | | | | 17. INFORMANT
<u>Mrs. Dorothy Bradshaw</u> | | | |
| 18. <u>412.41</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>chronic renal failure</u> | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<u>CVA</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>ASCVD</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 minutes</u>
<u>20 yrs</u>
<u>1 month</u> | |
| 19A. DATE OF OPERATION
<u>2 Nov</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>None</u> | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<u>None</u> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>None</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
<u>None</u> | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/1</u> 19 <u>69</u> to <u>6/5</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/5</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Richard W. Light</u> | | | | 23B. DATE SIGNED
<u>6/5/69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Richard W. Light</u> | |
| 23D. ADDRESS
<u>Johns Hopkins Hospital</u> | | | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | |
| 24B. DATE
<u>6/9/69</u> | | | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Laurel Grove Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Patterson, N.J.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 9 1969</u> | | | | 25B. NAME OF REGISTRAR
<u>Virginia E. Seaberg, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

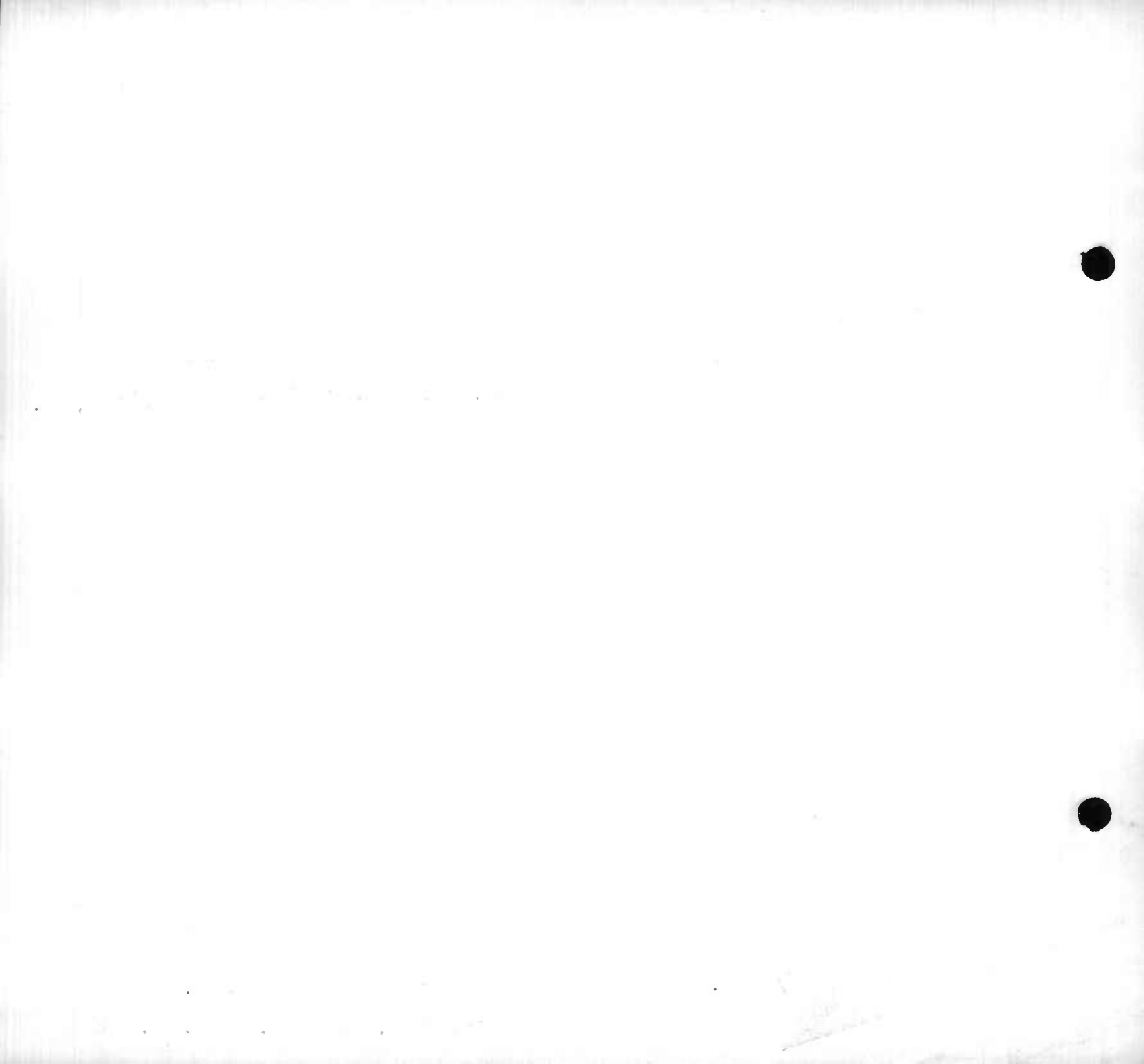
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5841</u> |
|--|---|---|--|---|
| BIRTH NO. | | 69 5841 | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| <u>AUGUST D. MANZO</u> | | <u>6/6/69 1245 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNION MEMORIAL HOSPITAL</u> | | A. STATE <u>Md.</u> B. COUNTY <u>27-45</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
<u>6006 BURGESS AVENUE</u> | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>09-06-03</u> | 9. AGE (In years last birthday)
<u>65</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED Balto.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>City Police Dept.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> |
| 13. FATHER'S NAME
<u>DANIEL MANZO</u> | | 14. MOTHER'S MAIDEN NAME
<u>ANNA M. DISAIA</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>216-01-2083</u> | | 17. INFORMANT
<u>Mrs. Anna M. Manzo</u> |
| | | | | ADDRESS
(Same) |
| 18. <u>7309</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Cardiac arrest</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Possible Subarachnoid hemorrhage</u> | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (C) _____ | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
<u>No</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (X) (this hospital) attended the deceased from <u>06-04</u> 19 <u>69</u> to <u>6-6</u> 19 <u>69</u> that (I) <u>Yes</u> last saw the deceased alive on <u>6-6</u> 19 <u>69</u> and that in (my) <u>Yes</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>Yes</u> (did) <u>Yes</u> view the body after death. | | | | |
| 23A. SIGNATURE
<u>Luis Gintado MD</u> | | 23B. DATE SIGNED
<u>6/6/69</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)
<u>LUIS GINTADO</u> | | 23D. ADDRESS
<u>UNION MEMORIAL HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>6/10/69</u> | 24C. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer Cemetery</u> | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 9 1969</u> | 25B. NAME OF REGISTRAR
<u>Leonard J. Buck, Inc.</u> | 25C. FUNERAL DIRECTOR
<u>Leonard J. Buck, Inc. Balto. Md. 21211</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

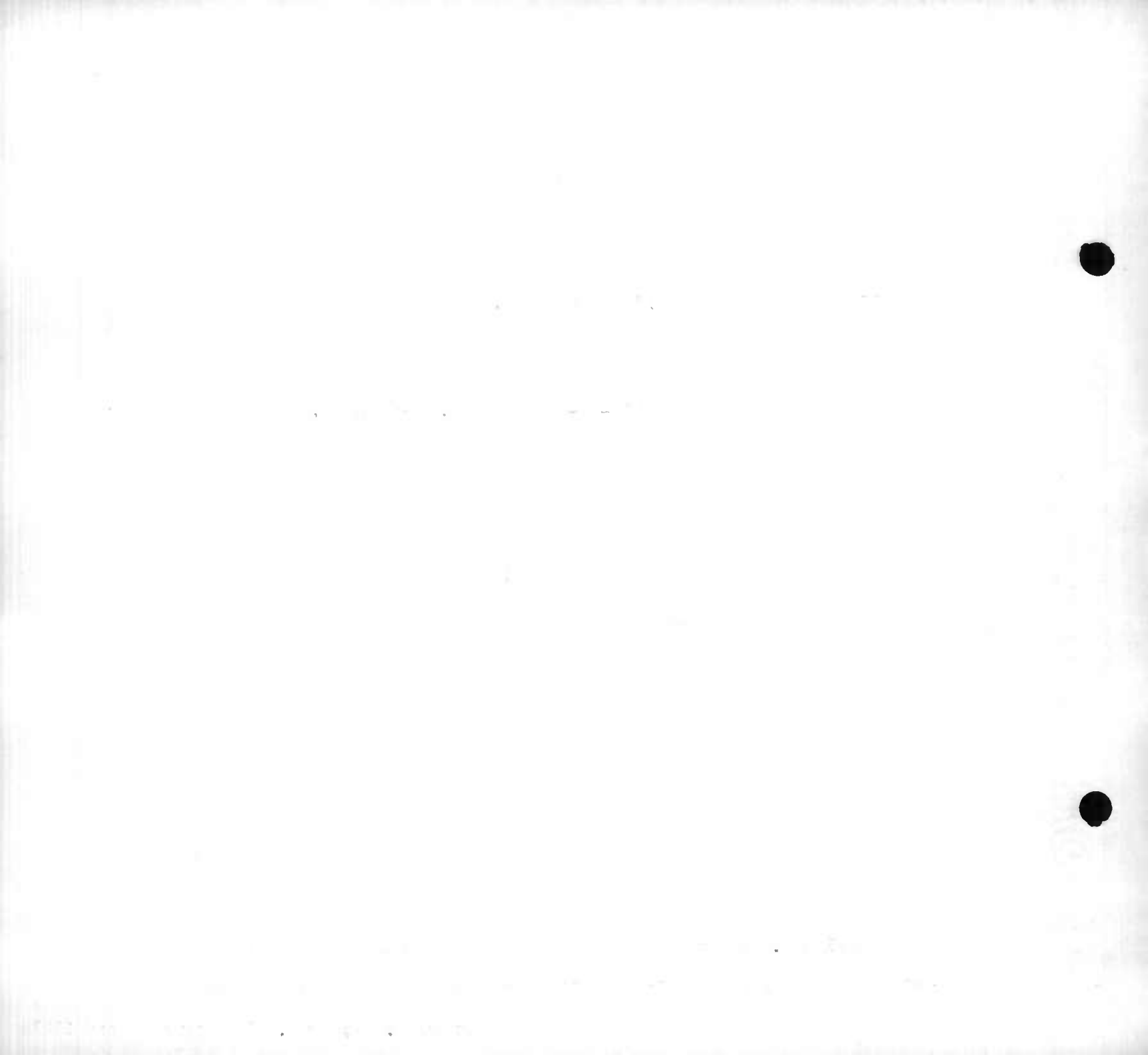
| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>69 5842</u> |
|---|--|---|--|---|
| BIRTH NO. <u>69 5842</u> | | 1. NAME OF DECEASED
(Type or Print) <u>MONIE J. MARTINO</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
<u>Maryland General Hospital</u> | | 2. DATE AND HOUR OF DEATH
<u>6-8-69</u> <u>5:30</u> A.M. | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | 5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>Maryland General Hospital</u> | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| E. STREET AND NUMBER
<u>1624 Hardwick Rd.</u> | | 8. DATE OF BIRTH <u>08/24/93</u> 9. AGE (In years last birthday) <u>75</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> |
| 13. FATHER'S NAME
<u>? Dix</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Carman</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>091 16 9717</u> | | 17. INFORMANT
<u>Mr. William L. Martino</u> ADDRESS <u>400 Underhill Place Alexandria, Va.</u> |
| 18. <u>7824 I</u> CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Cardiac failure</u>
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
_____ | | | | |
| 19A. DATE OF OPERATION
<u>06-10-69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
_____ | | 20A. AUTOPSY? (Yes or No)
<u>No</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)
_____ | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
_____ |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
_____ | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
_____ |
| 22. I certify that (I) (this hospital) attended the deceased from <u>05-27-69</u> to <u>06-8-69</u> that (I) (we) last saw the deceased alive on <u>06-8-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Ching-Hui Tsai, M.D.</u> | | 23B. DATE SIGNED
<u>6/8/69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Ching-Hui Tsai M.D.</u> |
| 24A. BURIAL CREMATION REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/10/69</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Moreland Memorial Cemetery</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 9 1969</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Fisher, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Legnath J. Ruck, Inc. Balto. Md. 21214</u> |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 69 5843 | |
|--|---------|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Joseph G. Weisinger | | June 6, 1969 7:50 a.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| 44 Union Memorial Hosp. | | Md. | | Baltimore 6 | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Towson | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 2 Acorn Circle | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| M | W | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 7/05/00 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | |
| Personell Manager | | Oil Company Ret. | | 68 | |
| 13. FATHER'S NAME | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Joseph Weisinger | | Maryland | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | 216-05-2300 A | | Mrs. Margaret M. Weisinger | |
| | | | | ADDRESS | |
| | | | | Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | (B) Carcinoma of Pancreas | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 4 1969 to June 6 1969 that (I) (we) last saw the deceased alive on June 6 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Charles R. Goshen | | | | June 6, 1969 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Charles R. Goshen | | Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 6/9/69 | | Dulaney Valley Cemetery | |
| | | | | Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 9 1969 | | Robert E. Taylor, M.D. | | Leonard J. Ruck Inc. 5305 Harford Road 21211 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE AMENDED

| Baltimore City Health Department | | | | REG. NO. 69 5844 | |
|---|--|--|--|---|--|
| BIRTH NO. 69 5844 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Pauline W. Grace | | 2. DATE AND HOUR OF DEATH
June 8, 1969 2:00 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
Maryland General Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 27-34 | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 8-11-05 | | 9. AGE (In years last birthday) 63 | | 10. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Harry Frank | | 14. MOTHER'S MAIDEN NAME Mable Dunlap | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 14-30-5254 | | 17. INFORMANT (Husband) Henry J. Grace ADDRESS same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebral edema, severe
Acute Myocardial Infarction
Fractures of left hip, multiple (2) recent
Arteriosclerotic Heart Disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Ischemic (arteriosclerotic) heart disease; sarcoidosis, treated | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hours
17 years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Ischemic (arteriosclerotic) heart disease; sarcoidosis, treated | | | | | |
| 19A. DATE OF OPERATION 2/1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Intersection of Belair & Pelham Roads | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) June 7, 1969 10 P.M. | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Slipped off sidewalk losing balance & falling into street | |
| 22. I certify that (I) (this hospital) attended the deceased from June 7, 1969 to June 8, 1969 and that (I) (we) last saw the deceased alive on June 8, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William L. Boddie M.D. | | 23B. DATE SIGNED 6-8-69 | | 23C. PHYSICIAN'S NAME (Type) William L. Boddie M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 6/12/69 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 9 1969 | | 25B. NAME OF REGISTRAR Leonard J. Buck, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS Balto. Md. | |

Letter from Dr.W.Bradley King,Jr. Pathologist & Director of Laboratories,
Maryland General Hospital, dated 7/7/69

B-6501

BALTIMORE CITY HEALTH DEPARTMENT

69 5845 CERTIFICATE OF DEATH

REG. NO. 69 5845

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CASSIE S. BRYAN

2. DATE AND HOUR OF DEATH

June 7, 1969.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5405 Bellevista Ave.

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☒

8. DATE OF BIRTH

Jan. 30, 1902.

9. AGE (In years
last birthday)

67.

If Under 1 Yr.
Months: Days:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William T. Slocum

14. MOTHER'S MAIDEN NAME

Mary Thorn

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

1-18-3313A

17. INFORMANT

ADDRESS

Mrs. J. Curtis Slocum, 1652 E. Belvedere Ave.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF

Coronary Embolism

(B) Fracture R. Leg Hypertension

(C) Myocardial Infarction

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 hours

10-28-68

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A)

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

yes

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home - garage

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

5405 Bellevista Ave.

21D. TIME
OF INJURY
(APPROX.)

June 5 - 1969

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☒

21F. HOW DID INJURY OCCUR?

Fall from open auto door (rear)

22. I certify that (I) (this hospital) attended the deceased from Oct 28-68 19 to 6-7-69 19
that (I) (we) last saw the deceased alive on 6-3-69 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

T. H. Hermann

DEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

6-9-69

23C. PHYSICIAN'S
NAME (Type)

T. H. HERRMANN

DEGREE

23D. ADDRESS

1710 E. 33rd St., Balto. Md. 21218

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/11/69.

24C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1969

25B. NAME OF REGISTRAR

Robert E. Staben, R.D.

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc.

ADDRESS

Balto. Md. 21214

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Handwritten text, possibly a signature or name, written vertically. Below the text is a horizontal line, and below that is a large, empty oval shape. To the right of the oval is an arrow pointing right, followed by the text "Function R Ltd".

1
R-100

69 5846 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5846

BIRTH NO. 64-02854

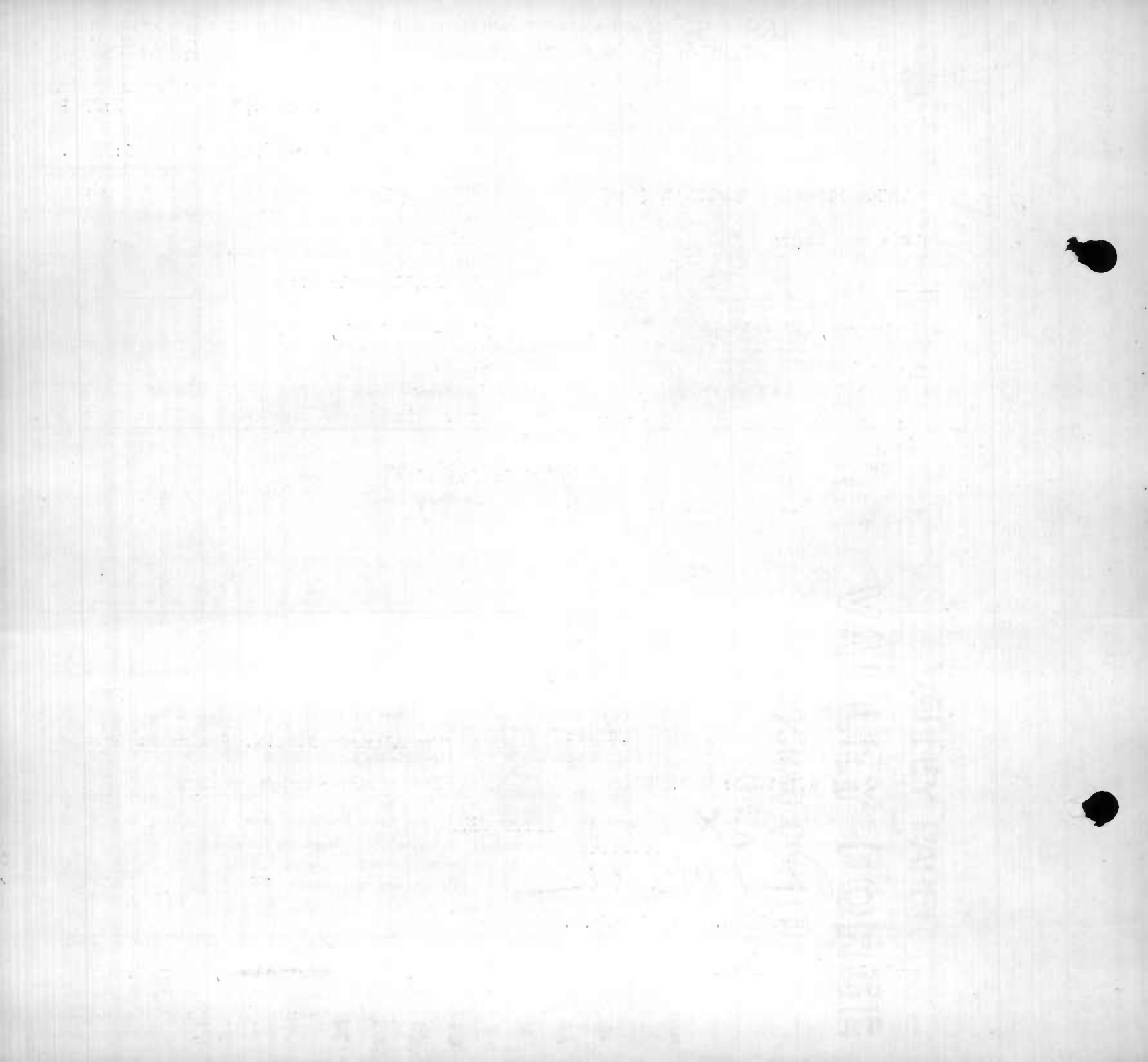
| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
BIRDIE RABB | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 6, 1969
Hour 3:55 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
UNION MEMORIAL HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 6, 1969
Hour 3:55 P. M. | |
| 6. SEX
Female | | 7. RACE
Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
2-3-1964 | | 10. AGE (In years lost birthday) 5
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Child | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 17. SOCIAL SECURITY NO.
-0- | |
| 15. MOTHER'S MAIDEN NAME
Birdie Mae Rabb | | 18. INFORMANT
Mrs. Birdie Rabb | |
| 13. FATHER'S NAME
Gilbert Rabb, Jr. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 15. MOTHER'S MAIDEN NAME
Birdie Mae Rabb | | ADDRESS
2406 Allendale St. | |

| | | | |
|---|--|--|--|
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Multiple injuries
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
Antecedent causes
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

| | | | | | |
|---|--|---|--|--|--|
| 20A. DATE OF OPERATION
2-3-1964 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
The Alameda, 34ft. N. of Winston Avenue | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)
June 6, 1969 3:20 P.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Pedestrian struck by auto | |

| | | | | | |
|---|--|--|--|------------------------------|--|
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
6/7/69 | |
| ACTUAL SIGNATURE
Ronald N. Kornblum
EXAMINER'S NAME (Type)
Ronald N. Kornblum, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |

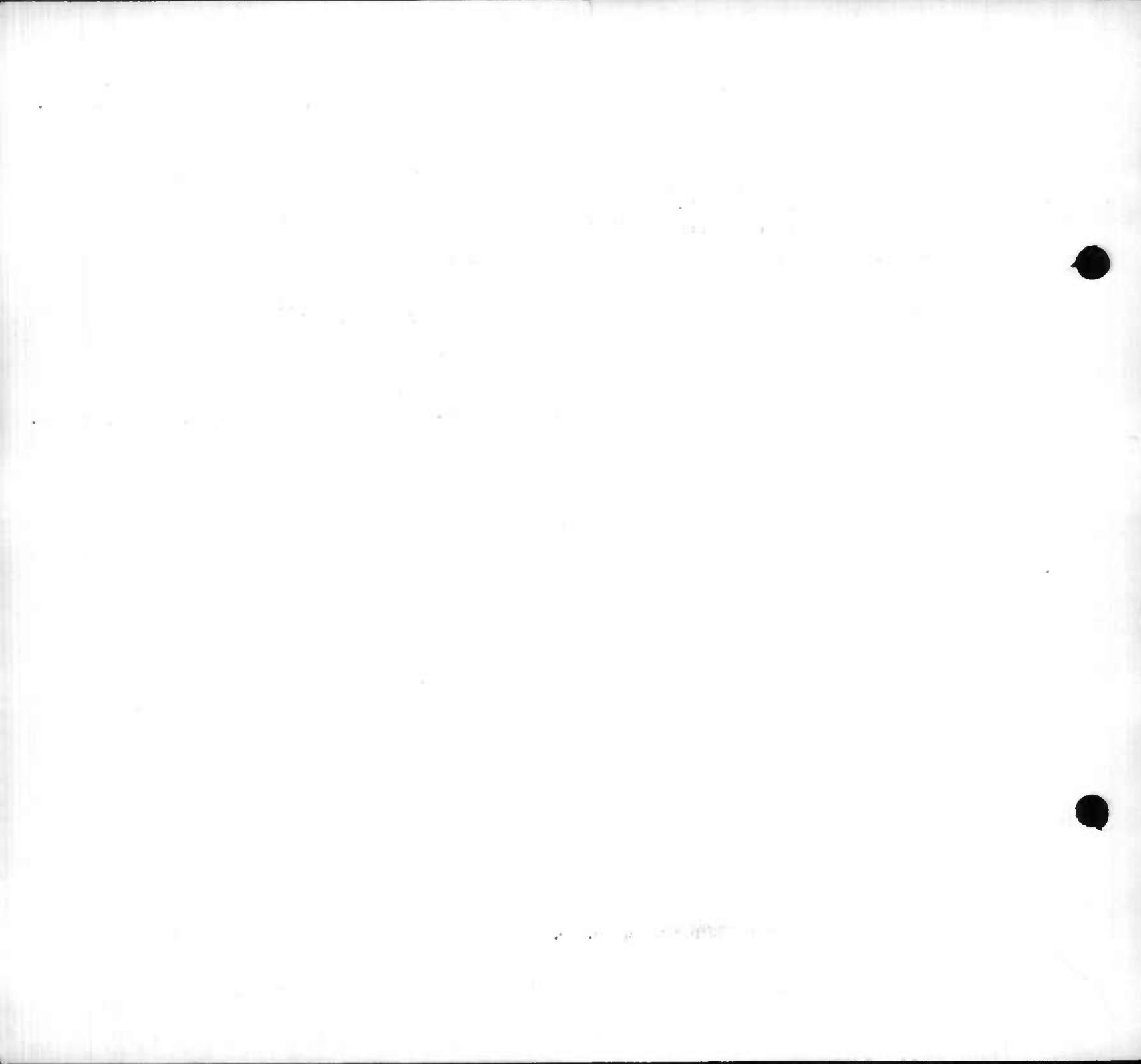
| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-10-69 | | 24C. NAME of CEMETERY or CREMATORY
Carver Memorial Pk. | | 24D. LOCATION (City, town, or county) (State)
Laurel, Maryland | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
6/10/69 | | 25B. NAME OF REGISTRAR
W. C. Vanden, M.D. | | 25C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | | ADDRESS
1701 Laurens St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 5847 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5847 | |
|--|------------------|---|----------------------------|---|-----------------------------|--|--|
| 1. NAME OF DECEASED
(Type or Print) Gladys Britt | | | | 2. DATE AND HOUR OF DEATH
June 5, 1969 9:00 p.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
39 Provident Hospital
1514 Division St.
Baltimore, Maryland 21217 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 13-03
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2428 McCulloh St | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-6-02 | 9. AGE (in years last birthday)
67 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
School Teacher | | 10B. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (State or foreign country)
Maryland, Balto. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Joseph T. Ray | | | | 14. MOTHER'S MAIDEN NAME
Estelle Ray | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
214-40-5361 | | 17. INFORMANT
Mrs. Miriam Nicholas 2307 Dukeland St. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
2. 2. 9. 1
CAUSE OF DEATH
RENAL FAILURE
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
DIABETES MELLITUS
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) GENERALIZED ARTERIOSCLEROSIS
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/4/69 1969 to 6/5 1969 that (I) (we) last saw the deceased alive on 6/5 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Gilbert Banfield, M.D. | | | | 23B. DATE SIGNED
6/6/69. | | 23C. PHYSICIAN'S NAME (Type)
Gilbert Banfield, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-10-69 | | 24C. NAME of CEMETERY or CREMATORY
Balto. Nat'l Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Morton S. Dyett | | 25C. FUNERAL DIRECTOR
Morton S. Dyett F.H. 1701 Laurens Street | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
ANDREW LEAK, Jr. | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 6, 1969
Hour 2:55 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
ST. AGNES HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 6, 1969
Hour 2:55 A.M. | |
| 6. SEX
Male | | 7. RACE
Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
Oct 31, 1945 | | 10. AGE (In years lost birthday) 23
If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME
Grace Leak | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Mrs. Margaret Leak | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Gunshot wound of head | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. DATE OF OPERATION | | 21. AUTOPSY? (Yes or No)
yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
Rear 325 N. Lyndhurst | | 22D. TIME (Month) (Day) (Hour) (Approx.) June 6, 1969 2:30 A.M. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Subject shot during altercation | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED
6/6/69 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-10-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | 25B. NAME OF REGISTRAR
Robert E. Farber, R.D. | |
| 25C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | | ADDRESS
1701 Laurens St. | |

WALTER R. HOLMES

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)E
MARGARET SNOWDEN2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

June 4, 1969

11:45 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

Sinai Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 4, 1969

11:45 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

15-11

6. SEX

Female

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

14-8-32

10. AGE (In years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Reid

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Essie Culp

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

218-26924

18. INFORMANT

ADDRESS

Bernadine Thomas, 4812 Palmer Ave

19.

E-950.1

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Salicylate intoxication
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3702 Dolfeld Avenue

22D. TIME
OF INJURY
(APPROX.)

6-4-69

(Month) (Day) (Year) (Hour)

?

22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Took overdose

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 5, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/9/69

24C. NAME OF CEMETERY or CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Wm. H. Smith

ADDRESS

1727 N. Meade St.

1914

George H. Hill
Lester C. Lippert
and others

1484 22 23
Meyers

1914

1914

1
D-120

69 5850 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5850

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

AGNES DAVIS

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ 5 31 69 8:10 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital D.O.A.

3. DATE PRONOUNCED DEAD Month Day Year Hour
May 31, 1969 8:10 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 20-37

6. SEX

Female

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

May 10-1910

10. AGE (In years last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

223 Mt. Holly Ave. St

11. BIRTH PLACE (State or foreign country)

Washington D.C.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

17. SOCIAL SECURITY NO.

217-22-4310

18. INFORMANT

Harry Davis

ADDRESS

223 Mt. Holly St

19. 571.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Liver cirrhosis
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Partial

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ P Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 1, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-4-69

24C. NAME OF CEMETERY or CREMATORY

St. Thomas

24D. LOCATION (City, town, or county) (State)

Randallstown, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

110

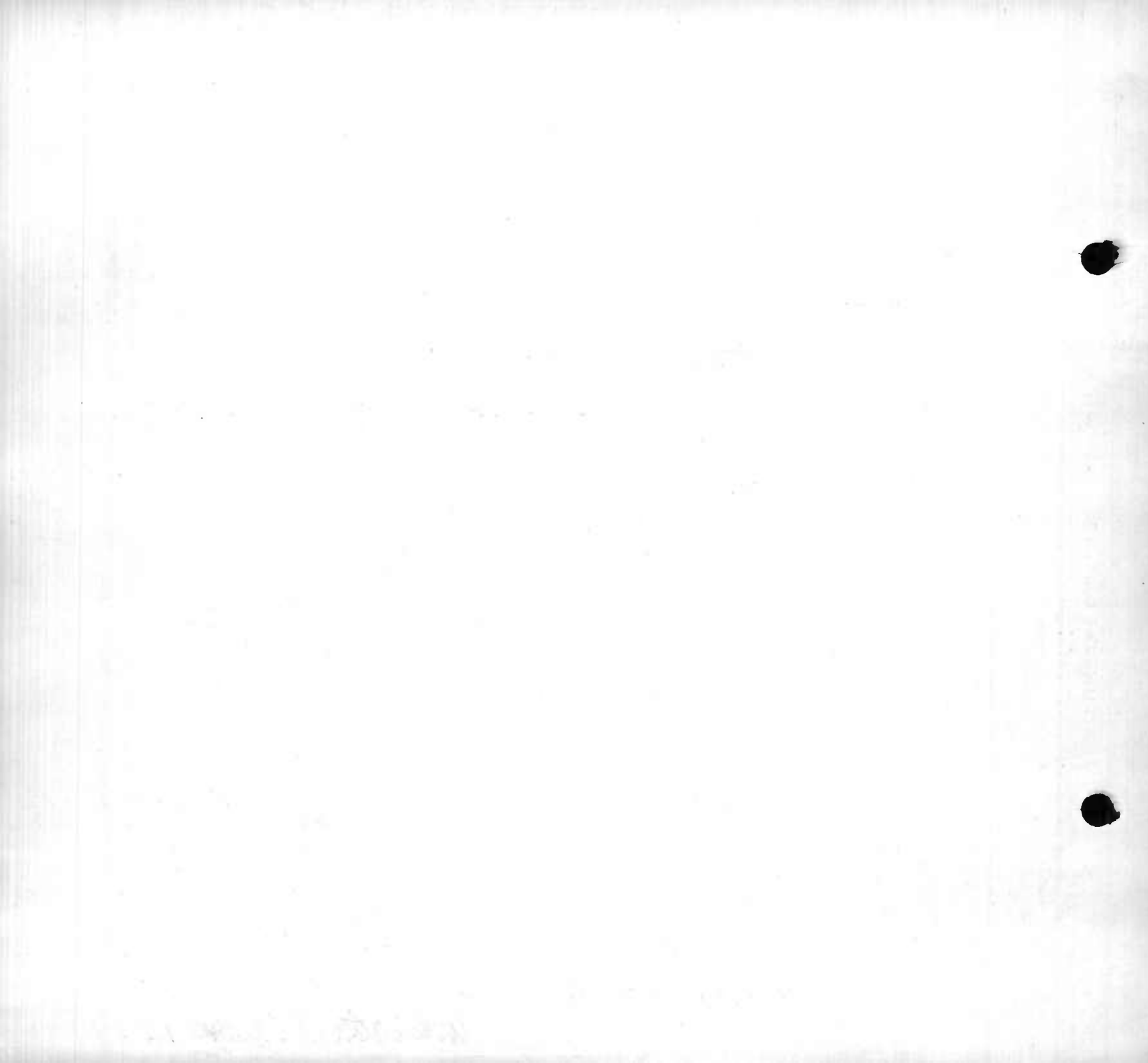
WALKER & CO. LTD.

2nd Floor

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 5851 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5851 | | | |
|---|--|----------------------|--|---|--|--------------------------------|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) <u>George W. Wood</u> | | | | 2. DATE AND HOUR OF DEATH
<u>June 2-69</u> <u>8.08 p.m.</u> | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>21207</u> | | | | C. CITY OR TOWN <u>Baltimore</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>Lutheran Hospital of Maryland</u> | | | | E. STREET AND NUMBER <u>5308 Belleville ave.</u> | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 5. SEX <u>Male</u> | | 6. RACE <u>negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-3-81</u> | | 9. AGE (In years last birthday) <u>88</u> | | 10. CITIZEN OF WHAT COUNTRY? <u>Virginia</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | | |
| 13. FATHER'S NAME <u>William Wood</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Jane Ball</u> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>224-53-8262A</u> | | | | 17. INFORMANT <u>Ann Pinn</u> | | | | ADDRESS <u>5308 Belleville ave</u> | | | |
| 18. <u>486 X1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
<u>Pneumonia</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Pneumonia</u>
(B) <u>Uremia</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3-4 days</u>
<u>2-3 Months</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | | |
| 21F. HOW DID INJURY OCCUR? | | | | 22. I certify that (I) (this hospital) attended the deceased from <u>May 23</u> 19 <u>69</u> to <u>June 2</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 2</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | 23A. SIGNATURE <u>Jun - Ja Chang</u> | | | |
| 23B. DATE SIGNED <u>June 2, 1969</u> | | | | 23C. PHYSICIAN'S NAME (Type) <u>Jun - Ja Chang</u> | | | | 23D. ADDRESS <u>Lutheran Hosp. of Maryland</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | | | 24B. DATE <u>6/6/69</u> | | | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Vernon</u> | | | |
| 24D. LOCATION (City, town, or county) <u>VA.</u> | | | | 25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1969</u> | | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | | |
| 25C. FUNERAL DIRECTOR <u>Belington A. Shulley</u> | | | | 25D. ADDRESS <u>1727 N. Moore</u> | | | | | | | |



1
P-626

69 5852 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5852

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SHIRLEY LEE PARKER

2. DATE OF DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

6

2

69

1:57 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Druid Hill Pk. Reservoir D.O.A.

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

June

2

1969

1:57 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

19-01

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

9. DATE OF BIRTH

1-30-34

10. AGE (In years last birthday)

35

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1709 West Fayette St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Cecil Widgeon

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Theresa Austin

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Theresa Austin

Same

19. 796.9

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 5, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/7/69

24C. NAME OF CEMETERY or CREMATORY

Canaan Mem. Ch. Laurel

24D. LOCATION

(City, town, or county) (State)

MD.

25A. DATE REC'D BY HEALTH DEPT.

JUN 8 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Wilmington Phillips 1727 N. Monro

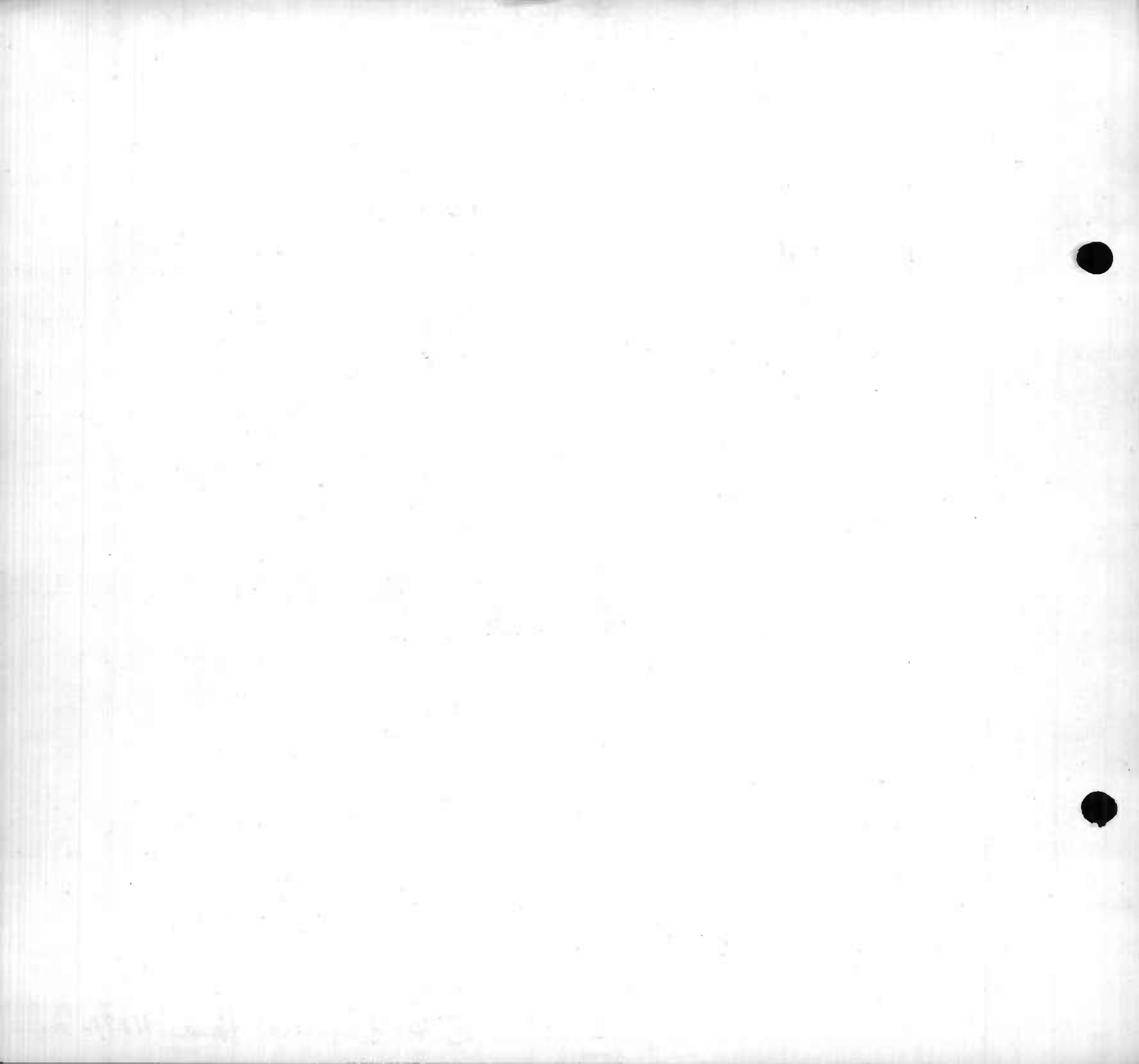
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5853 | |
|--|---------|---|------------------|--|----------------------------|
| <div style="display: flex; justify-content: space-between;"> 69 5853 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| IDA ALLEIN (nee Elder) | | A. STATE
B. COUNTY | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Harbort Nursing & Convalescent Center | | 4810 Hadden Ave | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days |
| F | N | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | May 6, 1899 | 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Isle of Wight County Va. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| George Butler | | Sarah ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Nursing Home Record | |
| 18. 4339 | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Days | |
| ANTECEDENT CAUSES | | (B) Multiple Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF: | | Weeks | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Arteriosclerosis, Generalized | | Years | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (If (this hospital) attended the deceased from May 30 1969 to June 6 1969, that (we) lost saw the deceased alive on June 6 1969 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| A.C. ALEVIZATOS, M.D. | | June 6, 1969 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| A.C. ALEVIZATOS, M.D. | | 1209 57th Street, Baltimore, Md 21202 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | June 10, 1969 | | Mt Auburn Cem | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUN 9 1969 | | John E. Jackson, M.D. | | Elgott Funeral Home 1129 N. Calver | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5854 |
|--|--|--|--|---|
| BIRTH NO. 69 5854 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Cora Wells | | 2. DATE AND HOUR OF DEATH
June 4, 1969 9:55 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
1812 Barclay Street | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY 12-05 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX Female | | 6. RACE Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH
Jan. 1, 1883 | | 9. AGE (In years last birthday) 86 | | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
Abram Proctor | | |
| 14. MOTHER'S MAIDEN NAME
Hester Jackson | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Clara Dixon | | |
| 18. 410.01 | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
Cowdery Thrombosis
DUE TO, OR AS A CONSEQUENCE OF | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Hypertension
DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (C) Coronary Arteriosclerosis | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Serixity | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 6/1 1967 to 6/4 1969 , that (I) (we) last saw the deceased alive on 6/3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (we) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Albert L. LaForest | | 23B. DATE SIGNED
6/6/69 | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)
DR ALBERT L. LAFOREST | | 23D. ADDRESS
822 N. Bond St Baltimore MD 21205 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
June 9/69 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cem |
| 24D. LOCATION
A. A. County Md | | 24E. DATE REC'D BY HEALTH DEPT.
JUN 9 1969 | | |
| 24F. NAME OF REGISTRAR
Wm E. Taylor, M.D. | | 24G. FUNERAL DIRECTOR
Spencer S. Elchman | | |
| 24H. ADDRESS
1129 N. Calver St | | | | |

| BIRTH NO. | | REG. NO. | |
|---|---|--|---|
| R-326 | | 68 5855 | |
| BALTIMORE CITY HEALTH DEPARTMENT | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE OF DEATH | |
| DANIEL RODGERS | | Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 4, 1969 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 3. DATE PRONOUNCED DEAD | |
| Johns Hopkins Hospital (DOA) | | Month Day Year
June 4, 1969 | |
| 6. SEX | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| Male | 7. RACE
Negro | A. STATE
Maryland | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH
2-27-45 | 10. AGE (In years last birthday)
24 | E. STREET AND NUMBER
2628 Kent St. | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | 13. FATHER'S NAME
Wilbert Mimmins | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
City | 14B. KIND OF BUSINESS OR INDUSTRY
Sanitation | 15. MOTHER'S MAIDEN NAME
Blanch Rodgers | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)
No | 17. SOCIAL SECURITY NO. | 18. INFORMANT
Blanch Wilson 2628 Kent St. | |
| 19. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | Intravenous narcotism
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 21. AUTOPSY? (Yes or No)
Yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED
June 5, 1969 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
6-9-69 | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland |
| 25A. DATE RECEIVED BY HEALTH DEPT.
JUN 10 1969 | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | 25C. FUNERAL DIRECTOR
Charles A. Rice 661 W. Barre St. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. |
|--|----------------------|--|---|---|
| F-360 69 5856 | | 5856 | | |
| CERTIFICATE OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) SR. M. Nicola Reiter | | 2. DATE AND HOUR OF DEATH
6-4-1969 4:20 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission)
A. STATE Maryland B. COUNTY 10-02 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
94 Institute of Notre Dame | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER 801 Ainsworth Street | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-27-1884 AGE (In years, months, days) 84 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10B. KIND OF BUSINESS OR INDUSTRY Religious | | 11. BIRTHPLACE (State or foreign country) ROCKESTER, N.Y. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME Nicolas Reiter | | 14. MOTHER'S MAIDEN NAME Marie Schmor | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT SR. M. Stan. Kutha ADDRESS 801 Ainsworth St. |
| 18. 412.2.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Lobar Pneumonia | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Multiple emboli
DUE TO, OR AS A CONSEQUENCE OF: | | |
| (C) HASCPV | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (1) (this hospital) attended the deceased from July 1960 to June 2 1969 , that (1) (we) lost saw the deceased alive on June 2 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE John J. Darrell DEGREE | | 23B. DATE SIGNED 6/5/69 | | 23C. PHYSICIAN'S NAME (Type) John Darrell DEGREE |
| 23D. ADDRESS Randalltown, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 6-6-69 | | 24C. NAME OF CEMETERY or CREMATORY SISTERS CEMETERY |
| 24D. LOCATION (City, town, or county) (State) GLEN ARMY, BALT. CT. MARYLAND | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 10 1969 | | 25B. NAME OF REGISTRAR Robert E. Taber | | 25C. FUNERAL DIRECTOR RAYMOND J. CURRAN ADDRESS 817 SCARLET DR TOWSON, MD 21204 |

Doc. p.

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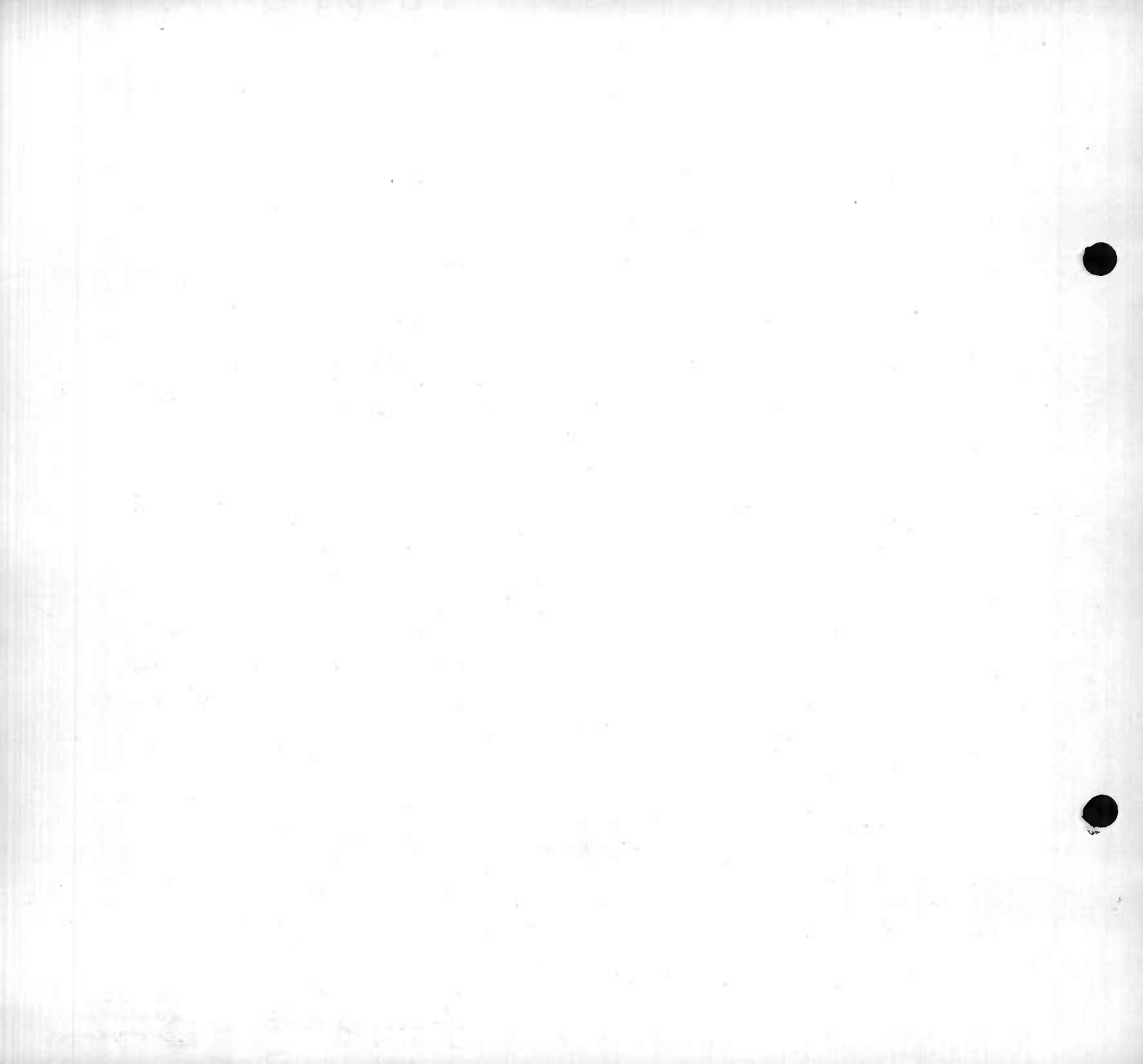
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

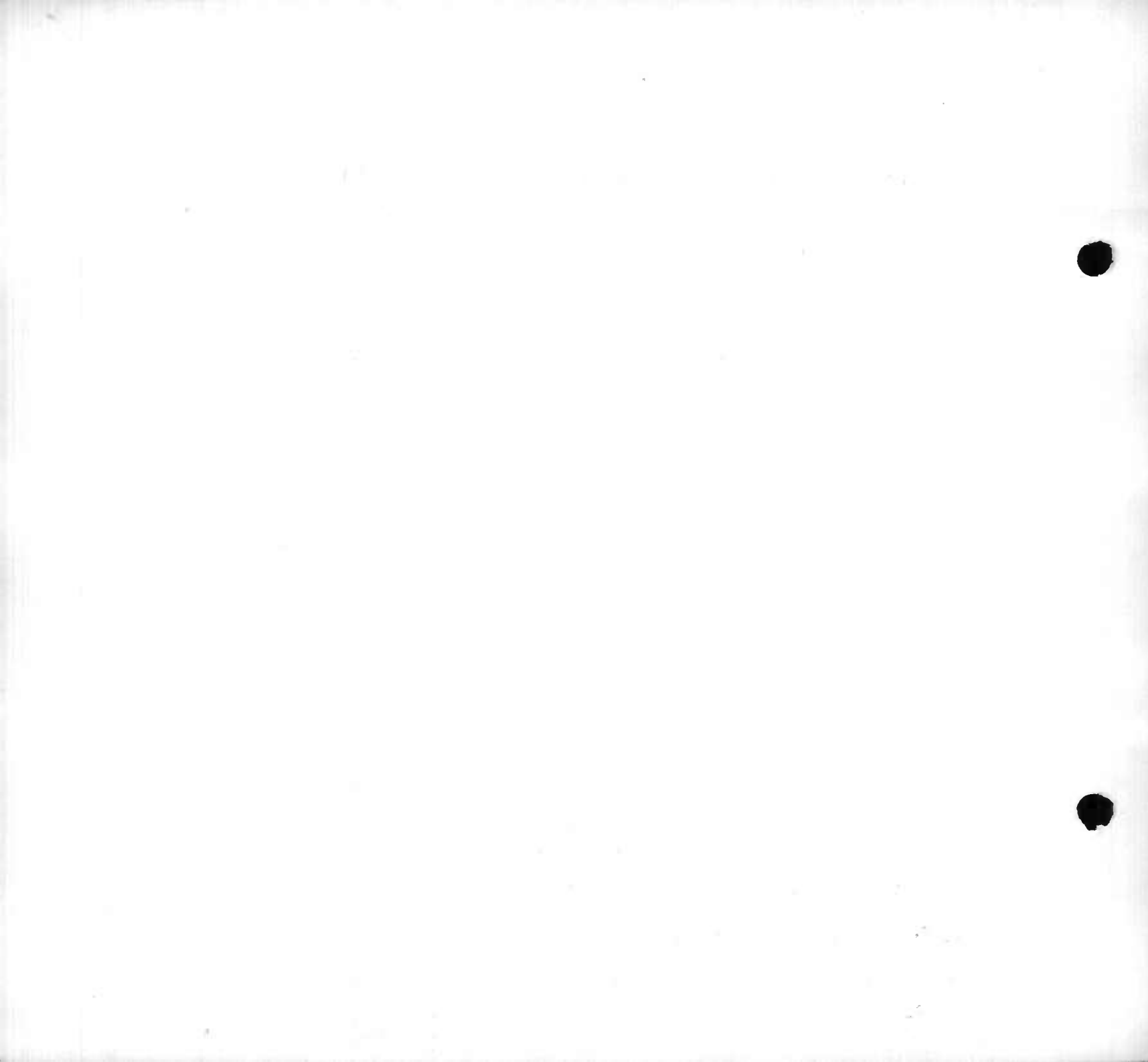
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5857 | |
|--|--|--|--|---|--|
| T-512 69 5857 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print)
Ada Thompson | | 2. DATE AND HOUR OF DEATH
6/6/69 1:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY Balto. # 21226 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Harbor View Nursing And Convalescent Home. | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
10/2/83 | | 9. AGE (In years lost birthday)
85 | | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Daniel Hadaway | | 14. MOTHER'S MAIDEN NAME
Alice Jones | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
- | | 16. SOCIAL SECURITY NO.
214-18-7002 | | 17. INFORMANT
Andreas Heying | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Intermittent Cardiac Disease | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Intermittent Cardiac Disease
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
200. | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from April 27 19 69 to June 6 19 69 , that we lost saw the deceased alive on June 6 19 69 and that in my our opinion death occurred on the date and hour and from the causes stated above. (4) We did did not view the body after death. | | | | | |
| 23A. SIGNATURE
C. C. Alevizatos, MD | | 23B. DATE SIGNED
June 6, 1969 | | 23C. PHYSICIAN'S NAME (Type)
C. C. ALEVIZATOS, MD | |
| 23D. ADDRESS
1209 St. Paul St. Baltimore Md 21202 | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | |
| 24B. DATE
6/9/69 | | 24C. NAME OF CEMETERY or CREMATORY
Chesnut | | 24D. LOCATION (City, town, or county) (State)
Chesnut St & Md. Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, Jr. | | 25C. FUNERAL DIRECTOR
William C. Williams | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5858 | |
|--|------------------|---|-----------------------------|---|---------------------------------|
| BIRTH NO. 69-09471 | | 69 5858 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | MILLARD P. SMITH | | 2. DATE AND HOUR OF DEATH
6-5-69 2:18P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE
MARYLAND | |
| C. CITY OR TOWN
GLEN BURNIE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| E. STREET AND NUMBER
303 FURNACE BRANCH RD. | | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-26-69 | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: 11 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
CHARLES M. SMITH | | | |
| 14. MOTHER'S MAIDEN NAME
DOROTHY ENSENOT | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
ANOREXIA
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) RECURRENT PLEURAL EFFUSIONS
DUE TO, OR AS A CONSEQUENCE OF: AND PNEUMOTHORACES | | | |
| (C) HYDROPS FETALIS | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/26 19 69 to 6/5 19 69 that (I) (we) last saw the deceased alive on 6/5/69 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
D. L. Headings M.D. | | 23B. DATE SIGNED
6/5/69 | | 23C. PHYSICIAN'S NAME (Type)
D. L. HEADINGS, M.D. | |
| 23D. ADDRESS
JOHNS HOPKINS HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | | |
| 24B. DATE
6/6/69 | | 24C. NAME OF CEMETERY or CREMATORY
The Johns Hopkins Hosp. | | 24D. LOCATION (City, town, or county) (State)
601 N. Broadway, Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
Robert E. Talbot, R.D. | | 25C. FUNERAL DIRECTOR ADDRESS
5 HOSPITAL DISPOSAL | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 69 5859 |
|--|--|---|---|--|
| BIRTH NO. W-100 | | 69 5859 | | |
| 1. NAME OF DECEASED
(Type or Print) Viviette Webb | | 2. DATE AND HOUR OF DEATH
June 8, 1969 1 10⁴⁵ A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 14-03 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
4 Maryland General Hospital | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
1820 McCulloh St. | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-28-33 | 9. AGE (In years last birthday)
35 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
US | | 13. FATHER'S NAME
Prince Walker | | |
| 14. MOTHER'S MAIDEN NAME
Jessie Lindsay | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | |
| 16. SOCIAL SECURITY NO.
UNKNOWN | | 17. INFORMANT
John WEBB - 1820 Mt. Cullloch St. BALTO. MD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
I
BRONCHOPNEUMONIA | | CAUSE OF DEATH
BRONCHOPNEUMONIA | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
CARCINOMA MAMMARY | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
CARCINOMA | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF:
CARCINOMA | | |
| | | (C) CARCINOMA | | 2 yrs |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION
2/2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
yes |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 6-2-69 1969 to 6-8 1969 that (I) (we) last saw the deceased alive on 6-8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Donald W. Ryan | | 23B. DATE SIGNED
6-8-69 | | 23C. PHYSICIAN'S NAME (Type)
K. Owens |
| 23D. ADDRESS
MD | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | |
| 24B. DATE
6/12/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Arbiter Mem. PK. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Wm. C. Chatman, Jr. 1701 Mt. Cullloch St. Balto. Md. |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 69 5860 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | | 69 5860 | |
|---|-------------------------|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) <u>HEILNER ROSE LAUER</u> | | | | 2. DATE AND HOUR OF DEATH
<u>6 June '69</u> <u>14</u> <u>20</u> <u>17</u> M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>Balt.</u> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>33</u>
<u>Johns Hopkins Hospital</u> | | | | C. CITY OR TOWN
<u>Balt.</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | E. STREET AND NUMBER
<u>1701 Eutanaw Place Apt 4H.</u> | | | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>12-6-83</u> | 9. AGE (In years last birthday)
<u>85</u> | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. BIRTHPLACE (State or foreign country)
<u>BALTIMORE, MARYLAND</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED Setty</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>SECRETARY</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>Selig Heilner</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Rose Rosen LAUER</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>MR. HAROLD COHEN, 3601 CLARKS LANE, APT. 211</u> | | | |
| 18. <u>230.2 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
<u>SMALL INTESTINAL OBSTRUCTION</u>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>ILEAL TUMOR</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>HASCUD</u> | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>6/5</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>S.I.B.O.</u> | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <u>he</u> (this hospital) attended the deceased from <u>6/6</u> <u>6/5</u> <u>1969</u> to <u>6/6</u> <u>1969</u> that (I) <u>we</u> last saw the deceased alive on <u>6/6</u> <u>1969</u> and that (in my) <u>we</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>James R. K. Condon MD</u> | | | | 23B. DATE SIGNED
<u>6/6/69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>James R. K. Condon, MD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>CREMATION</u> | | 24B. DATE
<u>6-8-69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>LOUDEN PARK</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTIMORE, MARYLAND</u> | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
<u>JUN 10 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | | ADDRESS | | | |

SMALL INTESTINAL CRYPTOCYTOMA
ILEAL TUMOR

LIASCOB

28

2/2

10 1/2 - 10 1/2
10 1/2 - 10 1/2

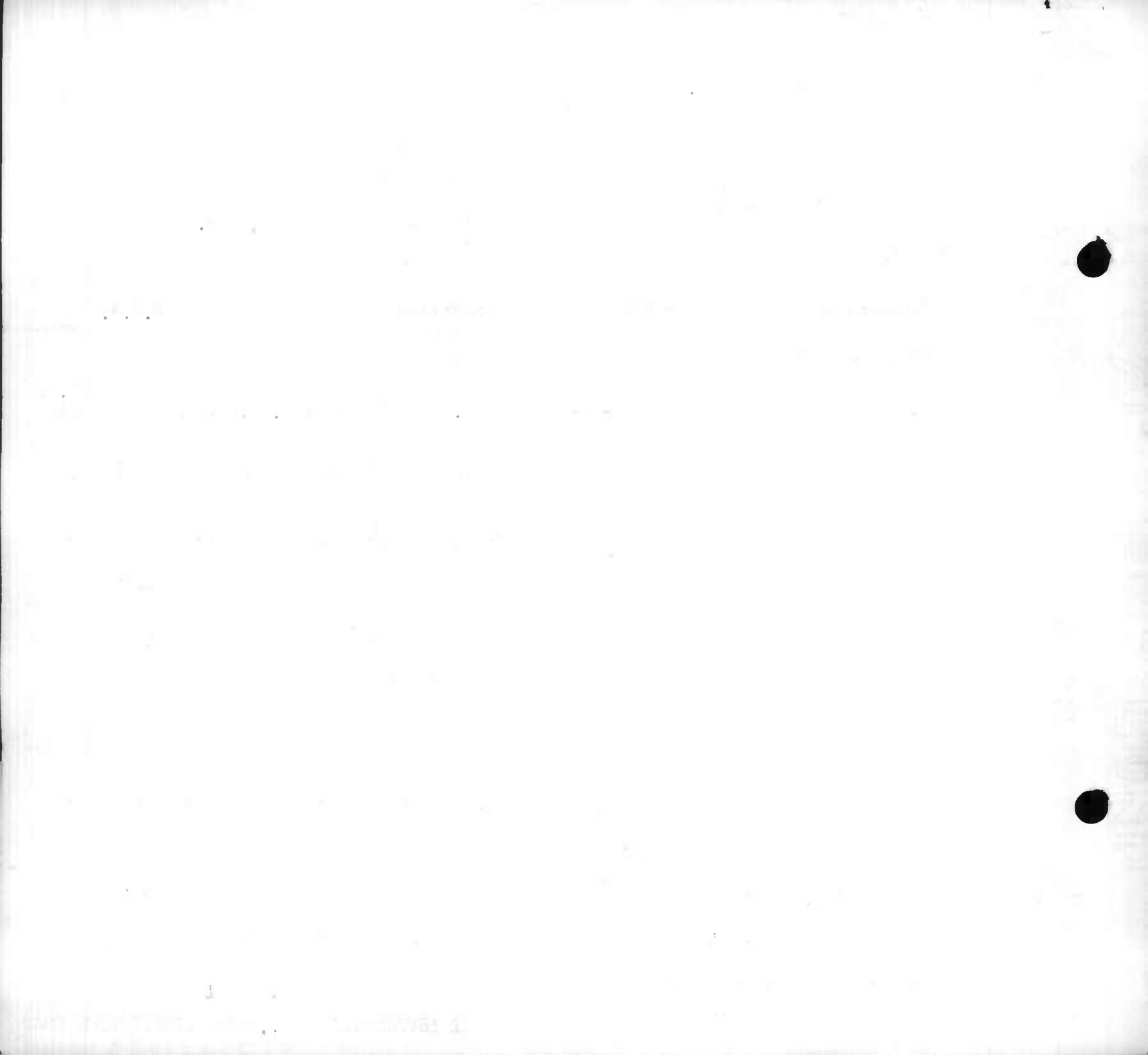
THOMAS R. WATSON MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5861 | |
|---|--|---|--|---|--|
| BIRTH NO.
1. NAME OF DECEASED
(Type or Print) Charles A. Blumberg | | 2. DATE AND HOUR OF DEATH
6/8/69 15:30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Sinai Hospital of Baltimore | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND B. COUNTY Balto. Co.
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 27 STONEHENGE CIRCLE, APT. 3 | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7/23/04 | 9. AGE (In years last birthday) 64 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PROPRIETOR | | 10B. KIND OF BUSINESS OR INDUSTRY
VENDING | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
MEYER BLUMBERG | | | |
| 14. MOTHER'S MAIDEN NAME
IDA ? | | 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NO | | | |
| 16. SOCIAL SECURITY NO.
218-32-2388 | | 17. INFORMANT ADDRESS APT. 3
MRS. BERTHA BLUMBERG, 27 STONEHENGE CIRCLE | | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE Acute Myocardial Infarc. 4 days
DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (B) Atherosclerotic Cardiovasc. Dis 10 years
DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) Brainstem CVA 6 days | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from June 2, 19 69 to June 8, 19 69 that (1) (we) last saw the deceased alive on June 8, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (and not) view the body after death. | | | | | |
| 23A. SIGNATURE
Barry Green, M.D. | | | | 23B. DATE SIGNED
6/8/69 | |
| 23C. PHYSICIAN'S NAME (Type)
Barry Green, M.D. | | | | 23D. ADDRESS
Sinai Hospital of Baltimore, Inc. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-9-69 | | 24C. NAME OF CEMETERY OR CREMATORY
RXXRXX CHIZUK AMUNO | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | | |
| 25B. NAME OF REGISTRAR
E. J. J. J. J. | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |



| BIRTH NO. | | | | REG. NO. | | | |
|---|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
DONALD HOLLIE | | | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 5, 1969 12:00 P.M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
LUTHERAN HOSPITAL (DOA) | | | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 5, 1969 12:00 P.M. | | | |
| 6. SEX
Male | | | | 7. RACE
White | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH
5-22-42 | | | | 10. AGE (In years last birthday)
27 | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF
USA | | | | 13. FATHER'S NAME
Jesse Hollie | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 15. MOTHER'S MAIDEN NAME
Myrtle Woodall | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes US Navy | | | | 17. SOCIAL SECURITY NO.
212-40-1796 | | 18. INFORMANT
Jesse Hollie-601 E. 29th Street Balto, Md. | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Multiple injuries
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
Multiple injuries
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Multiple injuries | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Hilton Pkwy. 2,000 ft. N. of Edmondson Avenue | |
| 22D. TIME OF INJURY (APPROX.)
June 5, 1969 11:45 P. | | | | 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Driver in tractor-trailer auto collision | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 6/6/69 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-10-69 | | 24C. NAME of CEMETERY or CREMATORY
Highland Burial Park | | 24D. LOCATION (City, town, or county) (State)
Danville, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
E. Faber, M.D. | | 25C. FUNERAL DIRECTOR
Armstrong Funeral Chapel | | ADDRESS
-4600 Liberty | |

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1862. It is a very long letter, and it contains a great deal of information about the state of the country at that time. It is a very important document, and it is one of the most interesting documents in the collection.

2. The second part of the document is a letter from the President of the United States to the Congress, dated January 3, 1862. It is a very long letter, and it contains a great deal of information about the state of the country at that time. It is a very important document, and it is one of the most interesting documents in the collection.

3. The third part of the document is a letter from the President of the United States to the Congress, dated January 3, 1862. It is a very long letter, and it contains a great deal of information about the state of the country at that time. It is a very important document, and it is one of the most interesting documents in the collection.

4. The fourth part of the document is a letter from the President of the United States to the Congress, dated January 3, 1862. It is a very long letter, and it contains a great deal of information about the state of the country at that time. It is a very important document, and it is one of the most interesting documents in the collection.

5. The fifth part of the document is a letter from the President of the United States to the Congress, dated January 3, 1862. It is a very long letter, and it contains a great deal of information about the state of the country at that time. It is a very important document, and it is one of the most interesting documents in the collection.

31-33-54

313354

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| D-552 | | 69 5863 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5863 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) <u>DUNNINGTON, M. CATHERINE Mary</u> | | | |
| 2. DATE AND HOUR OF DEATH
<u>JUNE 5, 1969 5:00 AM</u> | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>31 Baltimore City Hospitals</u>
<u>4940 EASTERN AVENUE</u>
<u>BALTIMORE, MARYLAND 21224</u> | | | |
| 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>26-34</u> | | | | C. CITY OR TOWN <u>Baltimore</u>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER <u>1107 Evans Way</u> <u>21205</u> | | | | 5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH <u>10-26-1909</u> 9. AGE (In years last birthday) <u>59</u> | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry Sorter</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Joseph Carpovich</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Dora Bodey</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT <u>Records: BCH-4940 Eastern Avenue</u> | | | | ADDRESS <u>21224</u> | | | |
| 18. <u>412.44-154.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>UREMIA</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>CHRONIC KIDNEY DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) <u>AS END</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>WKS</u>
<u>YRS</u>
<u>YRS</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>CA OF ADENOCARCINOMA - RECTUM</u> | | | | ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| 19A. DATE OF OPERATION <u>25/6/69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CANCER RECTUM</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (i) (this hospital) attended the deceased from <u>4/23/69</u> 19 to <u>6/5/69</u> 19, that (i) (we) last saw the deceased alive on <u>6/5/69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>K. Hyden</u> | | | | 23B. DATE SIGNED <u>6/5/69</u> | | 23C. PHYSICIAN'S NAME (Type) <u>K. Hyden</u> | |
| 23D. ADDRESS <u>4940 Eastern Avenue, Baltimore, Md.</u> | | | | 23E. DEGREE <u>BALTO CITY HOSP</u> | | 23F. ADDRESS <u>21224</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>6/9/69</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1969</u> | | 25B. NAME OF REGISTRAR <u>Robert J. ...</u> | | 25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u> | | ADDRESS <u>3000 E. Baltimore St</u> | |

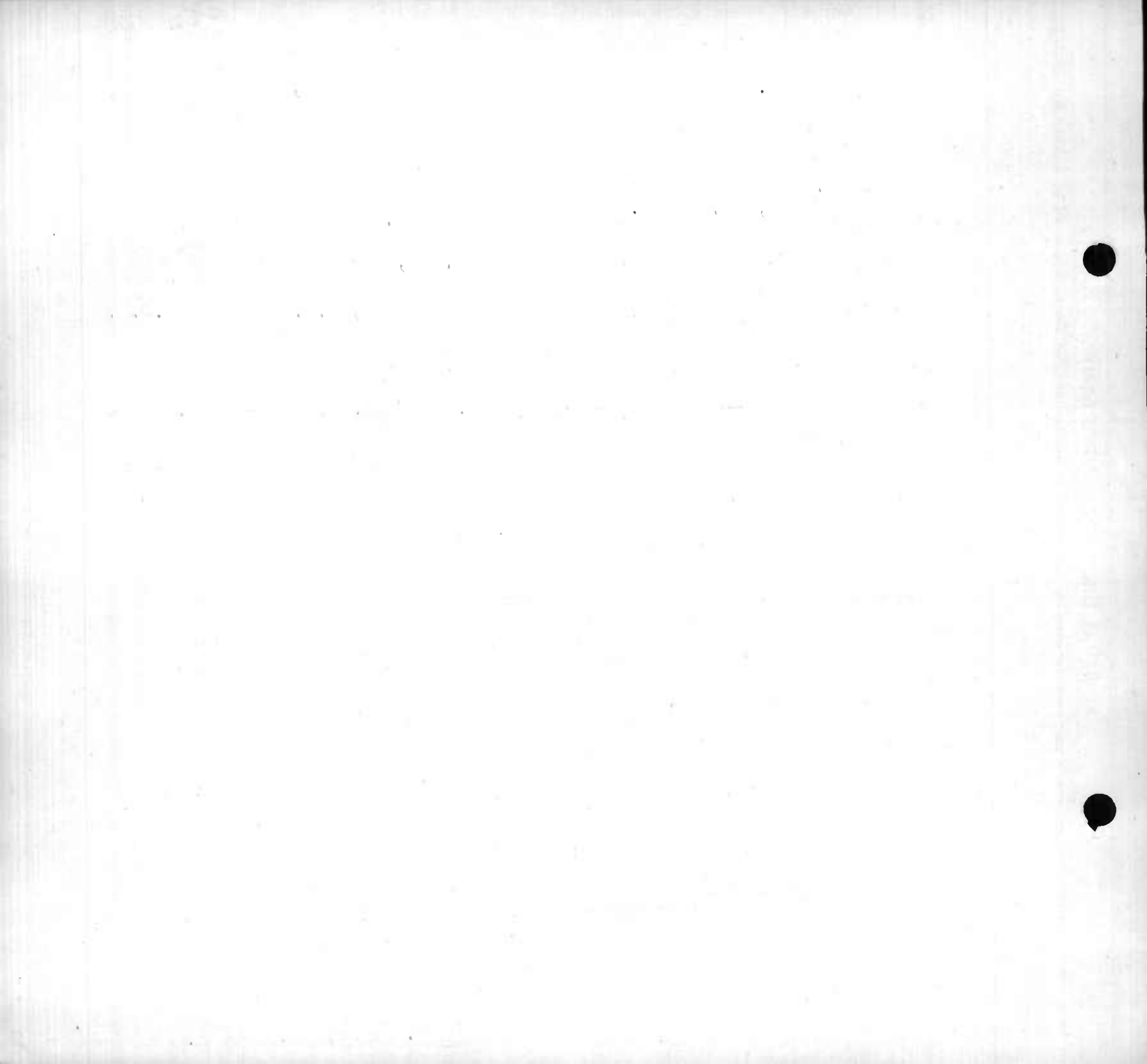


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5864 | |
|--|-------------------------|---|---|---|---|
| <div style="display: flex; justify-content: space-between;"> B-230 69 5864 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Charles M. Bassett</u> | | | 2. DATE AND HOUR OF DEATH
<u>June 7, 1969</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>00 428 N. Kenwood Avenue
Baltimore, Md. 21224.</u> | | | A. STATE <u>Maryland</u>
B. COUNTY <u>6-02</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<u>428 N. Kenwood Avenue</u> | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Mar. 19, 1909</u> | 9. AGE (In years last birthday)
<u>60</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Painter</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Self-Employed</u> | 11. BIRTHPLACE (State or foreign country)
<u>Plattsburg, N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>? Bassett</u> | | | 14. MOTHER'S MAIDEN NAME
<u>? </u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>212-22-3003</u> | | 17. INFORMANT
<u>Mrs. Doris V. Bassett-428 N. Kenwood Ave</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>151.9 I</u>
(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Hepatic failure</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<u>Cerebral stroke</u>
(C) <u>metastases</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u>
<u>4 months</u> |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>69</u> to <u>6/7/69</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/7/69</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>S. Munoz</u> | | | 23B. DATE SIGNED
<u>6/9/69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>S. MUNOZ, M.D.</u> |
| 23D. ADDRESS
<u>888 W. LOMBARD ST.</u> | | | 23E. FUNERAL DIRECTOR
<u>John A. Moran, Inc. 3000 E. Baltimore St.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/10/69</u> | | 24C. LOCATION (City, town, or county) (State)
<u>Oak Lawn Cemetery Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 10 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Tabor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>John A. Moran, Inc. 3000 E. Baltimore St.</u> | |



1

H-160 69 5865 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH X 69 5865

REG. NO.

BIRTH NO.

| | | | |
|---|---------------|---|--|
| 1. NAME OF DECEASED (Type or Print) S. RAYMOND HOOPER | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year June 6, 1969 Estimated <input type="checkbox"/> Hour 12:30 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS AND CITY, STATE OR COUNTRY) 31 CITY HOSPITAL 6-16-69 | | 3. DATE OF PRONOUNCED DEAD Month Day Year Hour June 6, 1969 12:30 P.M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 53-00 | | C. CITY OR TOWN Sparrows Point D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 6. SEX Male | 7. RACE White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | E. STREET AND NUMBER 1211 Beechwood Road |
| 9. DATE OF BIRTH Sept. 14, 1902 | | 10. AGE (In years last birthday) 66 | 11. BIRTHPLACE (State or foreign country) New York |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Frank Hooper | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethlehem Steel Co. | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME Josephine ? | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | |
| 17. SOCIAL SECURITY NO. 420-12-6944 | | 18. INFORMANT (Wife) ADDRESS Sparrows Pt. Mrs. Lena A. Hooper, 1211 Beechwood Rd. Md. | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | CAUSE OF DEATH Pulmonary embolism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Fracture of Left femur DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arteriosclerotic cardiovascular disease | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? N.pt. Blvd. 1600 ft. N. of Norris Lane 53-00 | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) May 26, 1969 9:53 P.M. | | 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? Pedestrian struck by auto | | 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 6/7/69 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 6/9/69 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JUN 10 1969 | |
| 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | |

VS 151-REV. 1/1/68

letter from M. C. W. office
6-16-69 MH.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>B-626</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5866</u> | | | |
|--|--------------|---|------------------|--|------------------------|--|-------------------------|-------------------------|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | | | |
| <u>Raymond A. Brookhart</u> | | | | <u>6-8-69</u> <u>1:00A M.</u> | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | | | | | |
| <u>40 St. Agnes Hospital</u>
<u>Caton & Wilkens Avenue</u>
<u>Baltimore, Maryland 21229</u> | | | | <u>Maryland</u> <u>Balto.co.</u> <u>53-00</u> | | | | | | | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | | | | |
| | | | | <u>Baltimore</u> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| | | | | E. STREET AND NUMBER | | | | | | | |
| | | | | <u>6002 Edmondson Avenue</u> <u>21228</u> | | | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days | 12. Under 24 Hrs. Hours | | | | |
| <u>Male</u> | <u>White</u> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <u>2-22-09</u> | <u>60</u> | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | | | | |
| <u>Plasterer</u> | | | | <u>Housing Authority</u> | | <u>Baltimore, Maryland</u> | | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| <u>John Brookhart</u> | | | | <u>Mary Emrine</u> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| <u>No</u> | | | | <u>218-09-8600</u> | | <u>Mrs. J. Dorothy Brookhart 6002 Edmondson Ave.</u> | | | | | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | <u>1 hr.</u> | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| | | | | <u>Acute Myocardial Infarction</u> | | | | | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | <u>atherosclerotic CVD</u> | | | | | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | | | | |
| | | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 7</u> 19 <u>66</u> to <u>June 8</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>May 25</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | | | |
| <u>J. Nelson McKay</u> | | | | <u>June 9, 1969</u> | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | | | |
| <u>J. Nelson McKay</u> | | | | <u>6014 Edmondson Avenue</u> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | | | | |
| <u>Burial</u> | | | | <u>6-11-1969</u> | | <u>Loudon Park Cemetery</u> | | | | | |
| | | | | 24D. LOCATION (City, town, or county) (State) | | | | | | | |
| | | | | <u>Baltimore, Maryland</u> | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | | | |
| <u>JUN 10 1969</u> | | | | <u>W. Cook-Brooks</u> | | <u>Towson 1050 York Rd. 21204</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|---------|--|------------------|--|---|
| R-162 | | 69 5867 | | 69 5867 | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| MAUDE RIVERS | | 109-32-1556 A | | 7:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. MARYLAND B. COUNTY | | | |
| Good Samaritan Hosp. | | DR. GONZALEZ | | 27-33 | |
| | | C. CITY OR TOWN | | BALTIMORE, MD. | |
| | | D. INSIDE CITY LIMITS? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | 2502 Montebello Terrace | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| F | Negro | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 1-20-1894 | 75 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| School Teacher | | | | Statesville, N. C. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Robert B. Murdock | | Rebecca Austin | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | 109-32-1556 A | | W. Leroy Berry, M. D. - 2502 Montebello Terr | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Congestive Heart Failure ~ 2 yr. | |
| ANTECEDENT CAUSES | | (B) Arteriosclerotic heart disease ~ 10 yr. | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/7 12/5 19 68 to 6/7 19 69, and that (I) (we) last saw the deceased alive on 6/7 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| John S. Urbanetti M.D. | | | | 6/7/69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| John S. Urbanetti M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Cremation | | 6-11-69 | | Fern Cliff Crematory | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Hartsdale West Chester Co., N.Y. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUN 10 1969 | | Robert E. Taylor | | Charles R. Law 802 Madison Ave., Balto, Md. | |



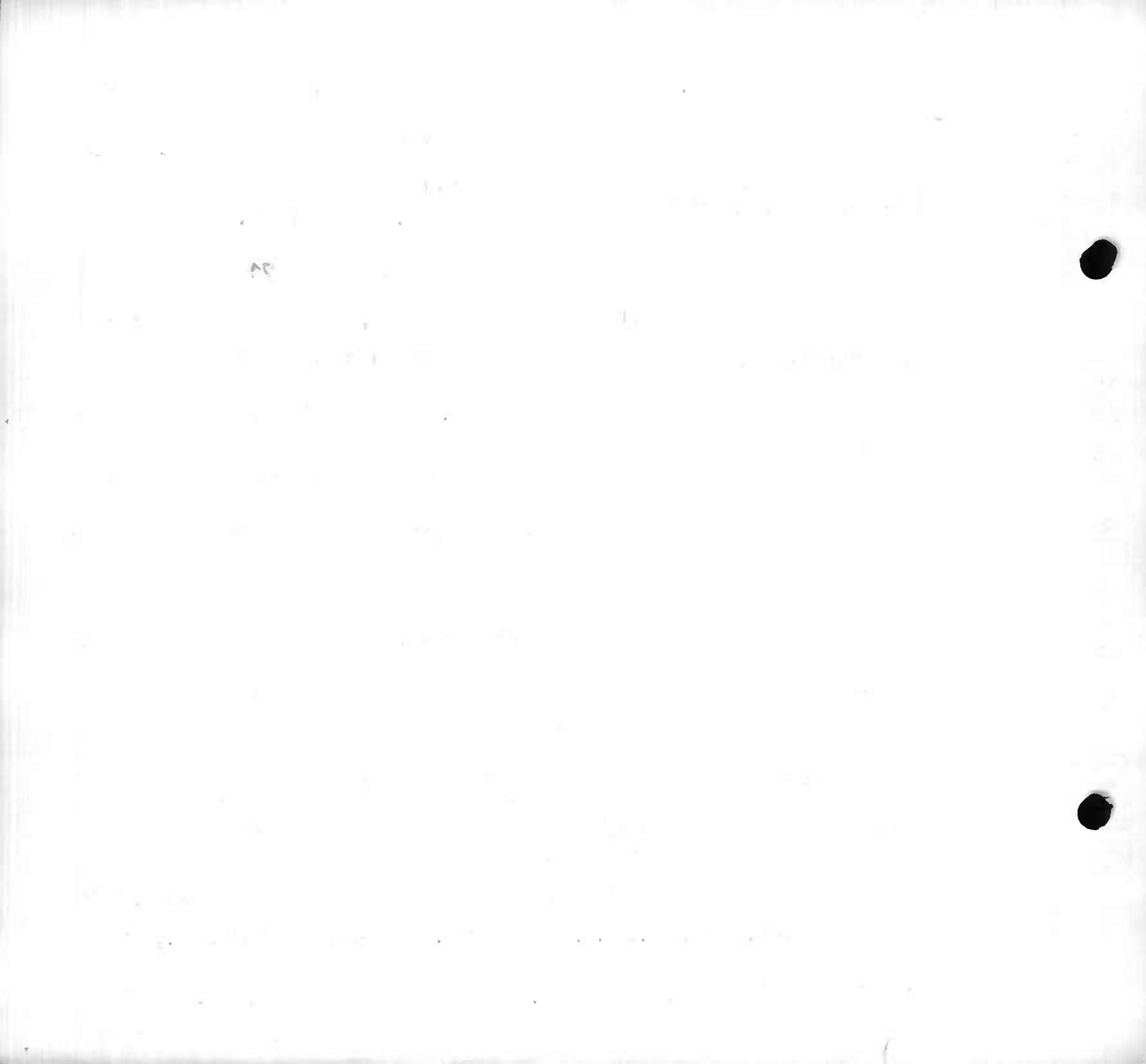
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5868 | |
|--|--------------|---|---|--|---|
| T-520 69 5868 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Charles E. Thomas | | June 3, 1969 5:35 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)

The Johns Hopkins Hospital
Baltimore, Maryland, 21205 | | | A. STATE
MARYLAND 15-03 | | |
| | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
1728 N. PULASKI ST. | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-18-98 | 9. AGE (In years last birthday)
70 | If Under 1 Tr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
RETIRED | | 11. BIRTHPLACE (State or foreign country)
Royal Oak, Maryland | |
| 13. FATHER'S NAME
JOSEPH THOMAS | | 14. MOTHER'S MAIDEN NAME
HENRIETTA GREEN | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
111106599 | | 17. INFORMANT
Mrs. Mildred Thomas 1728 N Pulaski St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Rupture of abdominal aneurysm 1/2 hour
DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerosis and hypertension 10 years
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Paget's Disease | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 years | | |
| 19A. DATE OF OPERATION
none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
XXXXXX | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>
no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
XXXX | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX)
XXXX | | 21E. INJURY OCCURRED
While At Work <input checked="" type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
XX | |
| 22. I certify that (1) (this hospital) attended the deceased from 5/25/19 69 to 6/3/19 69 that (1) (me) last saw the deceased alive on 6/3/19 69 and that (in my) (me) opinion death occurred on the date and hour and from the causes stated above. (1) (me) (did) (submit) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>George H. Sack, Jr.</i>
George H. Sack, Jr., M.D. | | | | 23B. DATE SIGNED
June 3, 1969 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
601 N. Broadway, Baltimore, Md., 21205 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/7/69 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Mem. Park | |
| 24D. LOCATION
Baltimore, Md. 21227 | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Feltz | | 25C. FUNERAL DIRECTOR
Lewis T. Gwynn 4517 Park Heights Ave. | | | |



| | | | | | |
|--|--------------------|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print)
LEEOLA GLOOCH Gooch | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
6 3 69 5:40 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
46 Lutheran Hospital | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 3, 1969 5:40 p.m. | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 16-05 | |
| 6. SEX
Female | 7. RACE
Colored | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN
Balto. | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH
Aug. 4, 1920 49 | | 10. AGE (In years lost birthday)
49 | E. STREET AND NUMBER
2216 Riggs Ave. | | |
| 11. BIRTHPLACE (State or foreign country)
Pickens County, S.C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | 13. FATHER'S NAME
Wash Bowens | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 14B. KIND OF BUSINESS OR INDUSTRY
Private | 15. MOTHER'S MAIDEN NAME
Mary Butler | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO.
249 20 0772 | 18. INFORMANT ADDRESS
Willie Gooch 2216 Riggs Ave. | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
412.41 | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
YES | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE: [Signature] M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/9/69 | 24C. NAME of CEMETERY or CREMATORY
Baltimore National | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
Robert S. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Lewis T. Gwynn 4517 Park Heights Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 69 5870 | REG. NO. |
|---|---------------------|--|-----------------------------------|---|--|
| BIRTH NO.
1. NAME OF DECEASED
(Type or Print) <i>Margaret Mary Kelley</i> | | 2. DATE AND HOUR OF DEATH
<i>6-7-69 6¹⁰ A. M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
<i>48 Maryland General Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE <i>Md</i> B. COUNTY <i>21234</i> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<i>City</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
<i>3122 Woodring Ave</i> | | | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>3-9-18</i> | 9. AGE (In years lost birthday)
<i>51</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Receptionist</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Balto Gas+Elect</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore Md</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | | | | |
| 13. FATHER'S NAME
<i>Charles Louis Gill</i> | | 14. MOTHER'S MAIDEN NAME
<i>Margaret H. Brandt</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>212 03 4817</i> | | 17. INFORMANT
<i>William E. Kelley, husband, above chart</i> | |
| 18. <i>199.0 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>carcinomatosis</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>7</i> | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>3-19-69</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Saundice</i> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <i>3-5-1969</i> to <i>6-7-1969</i> , that (I) (<u>we</u>) last saw the deceased alive on <i>6-7-1969</i> and that in (my) (<u>aur</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>James J. Hamby</i> | | 23B. DATE SIGNED
<i>6-7-69</i> | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6/10/69</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Gardens of Faith</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 10 1969</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>Schunnek Funeral Home, Inc.</i> | |
| 25D. ADDRESS
<i>3391 Brehms Lane</i> | | | | | |



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5871

BIRTH NO. _____

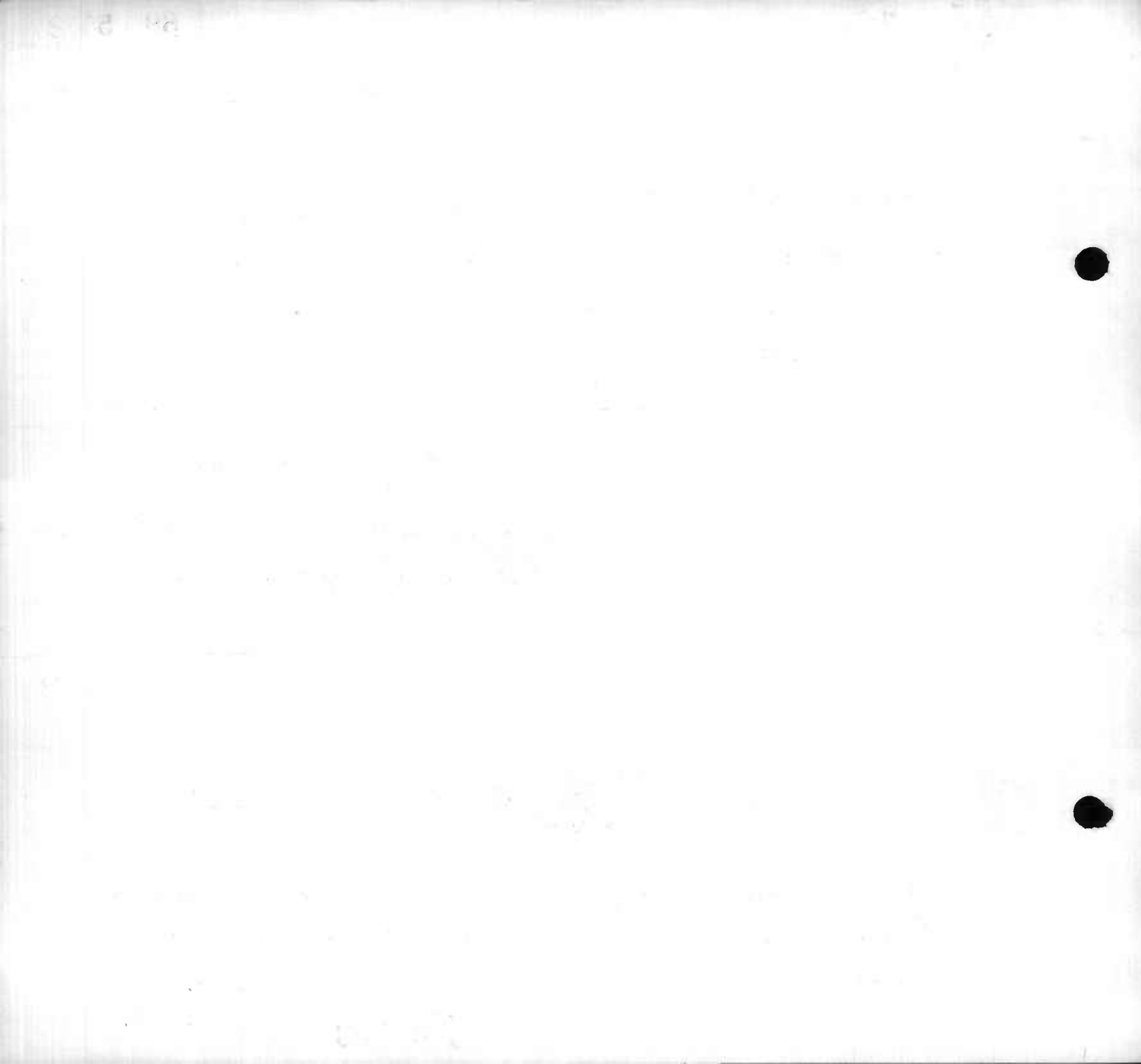
| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) Jackson
HOWARD /KAHL | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 6, 1969 11:38 A. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
CITY HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 6, 1969 11:38 A. M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
9/13/1913 | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years last birthday)
55 | | E. STREET AND NUMBER
5030 Erdman Avenue | |
| 11. BIRTHPLACE (State or foreign country)
xxxx Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
George Kahl | | 14. MOTHER'S MAIDEN NAME
Katherine Grubbs | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Guard Walters Art Gallery | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Helen Clark Kahl, wife, above | | ADDRESS | |
| 19. 149 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of Pharynx
DUE TO, OR AS A CONSEQUENCE OF:
(A) IMMEDIATE CAUSE
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION
0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Ronald N. Kornblum, M.D. DATE SIGNED 6/6/69
EXAMINER'S NAME (Type) | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/10/69 | |
| 24C. NAME of CEMETERY or CREMATORY
Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc. | | ADDRESS
3333 Brecht Lane | |

WILLIAM H. HUGHES
JAN 11 1964
—

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 68155872 | |
|--|---------------|---|-------------------------|--|-----------------------------|
| L-356 | | 69 5872 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED James LEWIS LEUTNER | | 2. DATE AND HOUR OF DEATH 6/6/69 1050A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Maryland | | 26-43 | |
| The Johns Hopkins Hospital | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 4128 Raymonn Avenue | | 21213 | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/4/14 | 9. AGE (In years last birthday) 55 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Grinding Operator | | Armco Steel | | Baltimore, Md. | |
| 13. FATHER'S NAME Albert Leutner | | 14. MOTHER'S MAIDEN NAME Lula Kraft | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-09-2662 | | 17. INFORMANT ADDRESS Margaret Jay Leutner, wife, above | |
| yes WW 2 | | | | | |
| 18. 398X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE 2 PULMONARY EMBOLISM | | 2 DAY | |
| ANTECEDENT CAUSES | | (B) CONGESTIVE HEART FAILURE | | 3 YEARS | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) RHEUMATIC HEART DISEASE | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CIRRHOSIS | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/4/69 19 to 6/6/69 19 that (I) (we) lost saw the deceased alive on 6/6/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jerome L. Rubin M.D. | | 23B. DATE SIGNED 6/6/69 | | 23C. PHYSICIAN'S NAME (Type) JEROME RUBIN M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 6/10/69 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. JUN 10 1969 | | 25B. NAME OF REGISTRAR 2668 722 529 0 0 0 | |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | 25D. ADDRESS 3831 Brehms Lane | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| M-620 | | 69 5873 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 69 5873 | |
|---|--------------|---|-----------------------------|---|----------------------------|-----------------------------|--|--|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| | | | | Magdalena Moric | | | | June 5, 1969 2 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | Md. Howard Co. | | | | 63-00 | |
| US Public Health Service Hospital
3100 Wyman Parkway | | | | C. CITY OR TOWN
Ellicott City | | | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
6821 All View Drive | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/22/98 | 9. AGE (in years last birthday)
71 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY
At Home | | | | 11. BIRTHPLACE (State or foreign country)
Austria | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | 13. FATHER'S NAME
Martin Kuzbel | | | | 14. MOTHER'S MAIDEN NAME
? Maria Gondova | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
082-10-3186 | | | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Generalized Breast Carcinoma
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
4 yrs | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 yrs | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
None | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from May 27 19 69 to June 5 19 69 that (1) (we) last saw the deceased alive on June 5 19 69 and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Stephen L. Goldware M.D. | | | | 23B. DATE SIGNED
6/5/69 | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Stephen L. Goldware (Surgeon R) | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | | | 24B. DATE
6/6/69 | | | | 24C. NAME OF CEMETERY or CREMATORY
Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Queens, L.I., New York | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | | | 25B. NAME OF REGISTRAR
J. B. R. | | | | 25C. FUNERAL DIRECTOR
Schmuck Funeral Home, Inc.
3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5874</u> |
|--|--|---|--|---|
| K-252 69 5874 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>MORRIS RESNICK</u> | | 2. DATE AND HOUR OF DEATH
<u>6/6/69</u> <u>10⁴⁵ A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>HOUSE IN THE PINES-BELVEDERE</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>27-17</u> | | |
| | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
<u>2525 W. BELVEDERE AVENUE</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1893</u> | 9. AGE (In years last birthday) <u>76</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Hosp chart</u> |
| | | ADDRESS | | |
| 18. <u>412.2 I</u> CAUSE OF DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>Cerebrovascular accident</u>

<u>HASCD</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 w/4</u>
<u>15 yrs 10</u> |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/25/69</u> 19 to <u>6/6/69</u> 19, that (I) <u>we</u> lost saw the deceased alive on <u>5/29/69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Joseph Shear M.D.</u> | | 23B. DATE SIGNED
<u>6/6/69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Joseph Shear M.D.</u> |
| 23D. ADDRESS
<u>6715 Park Heights Ave Baltimore MD</u> | | 23E. DEGREE
<u>MD</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>6/8/69</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>Shear Zion</u> | 24D. LOCATION (City, town, or county) (State)
<u>Balto Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 10 1969</u> | 25B. NAME OF REGISTRAR
<u>Rose L. Jones</u> | 25C. FUNERAL DIRECTOR
<u>Sylvanus Lewis & Son Inc 9610 Reisterstown Rd</u> | | |

1882

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|---------|--|---|--|---|--|
| C-620 | | 69 5875 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5875 | |
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Sarah Craig</i> | | | | June 6, 1969 4 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>12 Sini Hospital</i> | | | | A. STATE
<i>md</i> | | B. COUNTY
<i>15-12</i> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
<i>Balto</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
<i>F</i> | | | | 6. RACE
<i>W</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| 8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | B. DATE OF BIRTH
<i>Feb 22 1914</i> | | 9. AGE (In years lost birthday)
<i>55</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Russian</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | 13. FATHER'S NAME
<i>Louis</i> | | | |
| 14. MOTHER'S MAIDEN NAME
<i>Bessie</i> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
<i>Husband</i> | | | |
| ADDRESS
<i>Same</i> | | | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>230,914 174X</i> | | | |
| 19. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (A) IMMEDIATE CAUSE
<i>Coronary Heart failure</i> | | | | <i>24 hrs</i> | | | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| (B) <i>ASCUD</i> | | | | <i>years</i> | | | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| (C) <i>Diabetes mellitus</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | <i>Ca of the heart, right</i> | | | |
| 19. DATE OF OPERATION | | | | 20. AUTOPSY? (Yes or No)
<i>No</i> | | | |
| 21. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 23. PHYSICIAN'S NAME (Type) | | | | 24. DATE SIGNED
<i>6/6/69</i> | | | |
| 25. DATE REC'D BY HEALTH DEPT. | | | | 26. NAME OF REGISTRAR | | | |
| 27. FUNERAL DIRECTOR | | | | ADDRESS | | | |
| 28. NAME OF CEMETERY or CREMATORY | | | | 29. LOCATION (City, town, or county) (State) | | | |
| 30. DATE OF BURIAL, CREMATION, REMOVAL (Specify) | | | | 31. DATE OF BURIAL, CREMATION, REMOVAL (Specify) | | | |
| 32. NAME OF REGISTRAR | | | | 33. FUNERAL DIRECTOR | | | |
| 34. ADDRESS | | | | 35. ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. |
|--|--|---|--|---|
| B-215 | | 69 5876 | | 69 5876 |
| CERTIFICATE OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| ROSA BUXBAUM | | June 7, 1969 11:45 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
71 LEVINDALE HEBREW HOME | | A. STATE
Md
B. COUNTY
27-17 | | |
| 5. SEX
F | | 6. RACE
CAUC | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
11-11-86 |
| | | | | 9. AGE (In years and birthday)
83 |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Germany | | USA | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Hap |
| | | | | ADDRESS
Ches |
| 18. 410.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
1) Myocardial infarction 3 days
DUE TO, OR AS A CONSEQUENCE OF:
2) pulmonary infarction 3 days
3) urinary tract infection 4) septicemia 3 days
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) H. A. S. C. V. D. years. | | |
| 19. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 21 1966 to June 7 1969, that (I) (we) last saw the deceased alive on June 7 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Oscar Laborda M.D. | | 23B. DATE SIGNED
6-7-69 | | |
| 23C. PHYSICIAN'S NAME (Type)
OSCAR LABORDA M.D. | | 23D. ADDRESS
SINAI Hospital of Baltimore | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/9/69 | | 24C. NAME OF CEMETERY or CREMATORY
Baltic Hebrew |
| 24D. LOCATION
Baltic | | 24E. (City, town, or county) (State)
Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
J. J. J. | | 25C. FUNERAL DIRECTOR
Stephen Lewis & Son |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 69 5877 | |
|---|--|---|--|---|--|
| BIRTH NO. D-120 | | 1. NAME OF DECEASED
(Type or Print) Norman Charles Davis | | 2. DATE AND HOUR OF DEATH
June 8, 1969 5:35 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
US Public Health Service Hospital
3100 Wyman Parkway | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE Florida
B. COUNTY V-08
C. CITY OR TOWN Miami
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1221 Northeast First Ave. | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/11/04 | 9. AGE (In years last birthday) 64 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Seaman | | 11. BIRTHPLACE (State or foreign country) Wisconsin | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Frank W. Davis | | |
| 14. MOTHER'S MAIDEN NAME Veronica ? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes <input checked="" type="checkbox"/> USMC 1923-1924 | | |
| 16. SOCIAL SECURITY NO. 341-12-3488 | | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

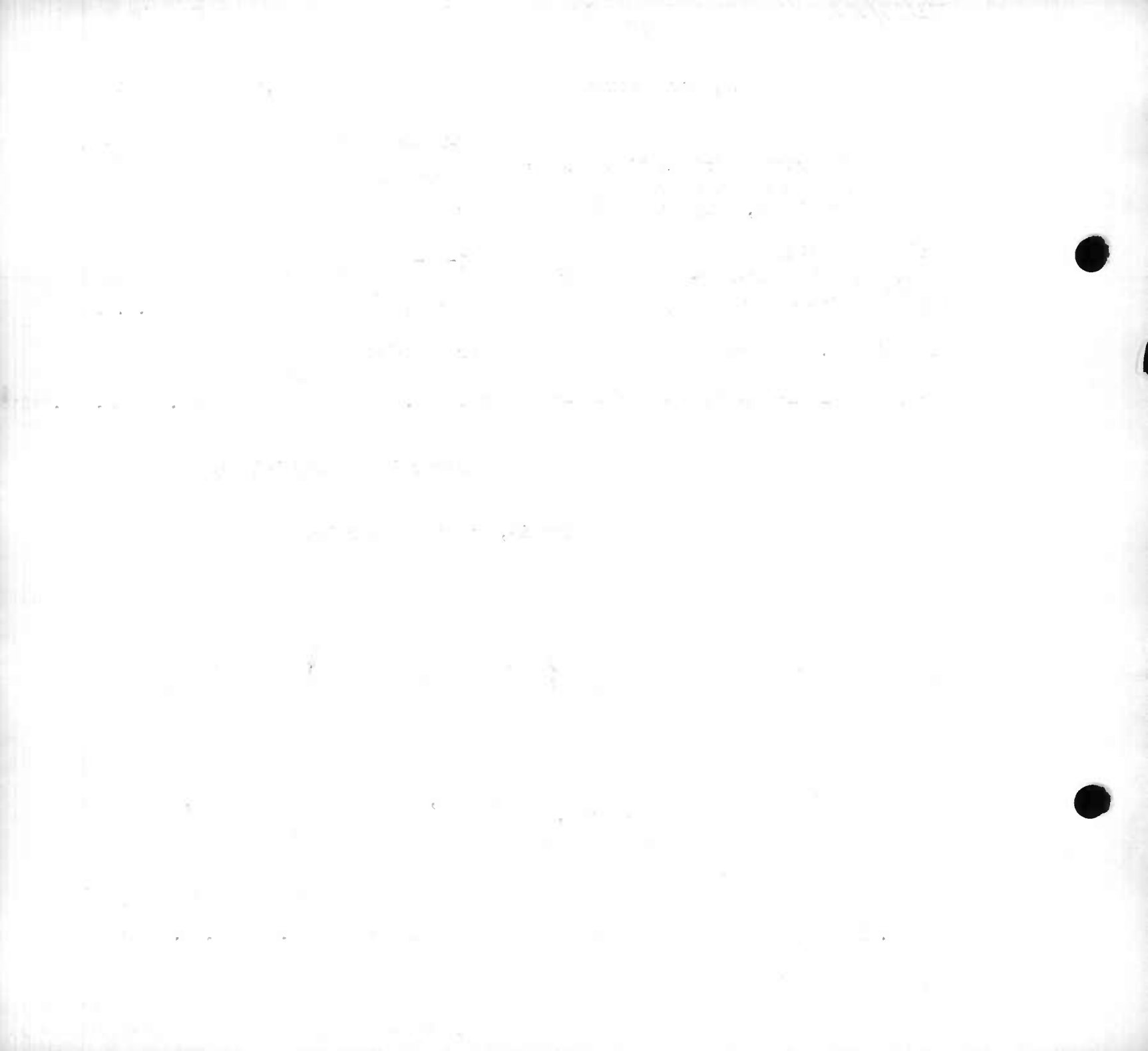
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive gastrointestinal hemorrhage | | | | Hours | |
| (B) Consumption coagulopathy DUE TO, OR AS A CONSEQUENCE OF: (clinically) | | | | Days | |
| (C) Carcinoma of the prostate, suspected | | | | Months | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I)/(this hospital) attended the deceased from May 10 19 69 to June 8 19 69 that (I)/(we) last saw the deceased alive on June 8 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)/(We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James M. Weaver | | | | 23B. DATE SIGNED 6/9/69 | |
| 23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 6-12-1969 | | 24C. NAME OF CEMETERY OR CREMATORY East Side Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Stanley, Wisconsin | | 25A. DATE REC'D BY HEALTH DEPT. JUN 10 1969 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, Md. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Baltimore City Health Department | | Baltimore City Health Department | |
|--|--|--|--|--|--|---|--|
| 69 5878 | | | | 69 5878 | | 69 5878 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | HELLMANN, Karl George | | June 8, 1969 12:30 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE
Maryland Baltimore | | B. COUNTY
Baltimore | |
| 23 Veterans Administration Hospital
3900 Loch Raven Blvd
Baltimore, Maryland 21218 | | | | C. CITY OR TOWN
Upper Falls | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER
McCubben Road | | | | 8. DATE OF BIRTH
11-24-92 | | 9. AGE (In years last birthday)
76 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown Retired | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Black & Decker Unknown | | 11. BIRTHPLACE (State or foreign country)
Tennessee | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Frederick J. Hellmann | | | | 14. MOTHER'S MAIDEN NAME
Martha Johns | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 1-31-18 to 1-22-19 | | | | 16. SOCIAL SECURITY NO.
216-07-3889 | | | |
| 17. INFORMANT
Records | | | | ADDRESS
VA, Hosp. 3900 Loch Raven Blvd. Balto. Md. 21218 | | | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE
Myocardial Insufficiency
DUE TO, OR AS A CONSEQUENCE OF:
(B) Anemia, Cause Undetermined
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Yes | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from June 7, 1969 to June 8, 1969 that (2) (we) last saw the deceased alive on June 8, 1969 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
S. Nasrallah | | | | 23B. DATE SIGNED
6/8/69 | | | |
| 23C. PHYSICIAN'S NAME (Type)
S. NASRALLAH MD | | | | 23D. ADDRESS
3900 Loch Raven Blvd. Balto. Md. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
6/11/1969 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National | |
| 24D. LOCATION
Baltimore Md | | | | 24E. LOCATION (City, town, or county) (State)
Baltimore Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | | | 25B. NAME OF REGISTRAR
Robert E. J. J. J. | | 25C. FUNERAL DIRECTOR
Charles F. Evans & Son | |
| | | | | 25D. ADDRESS
8802 Harford Rd | | | |



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

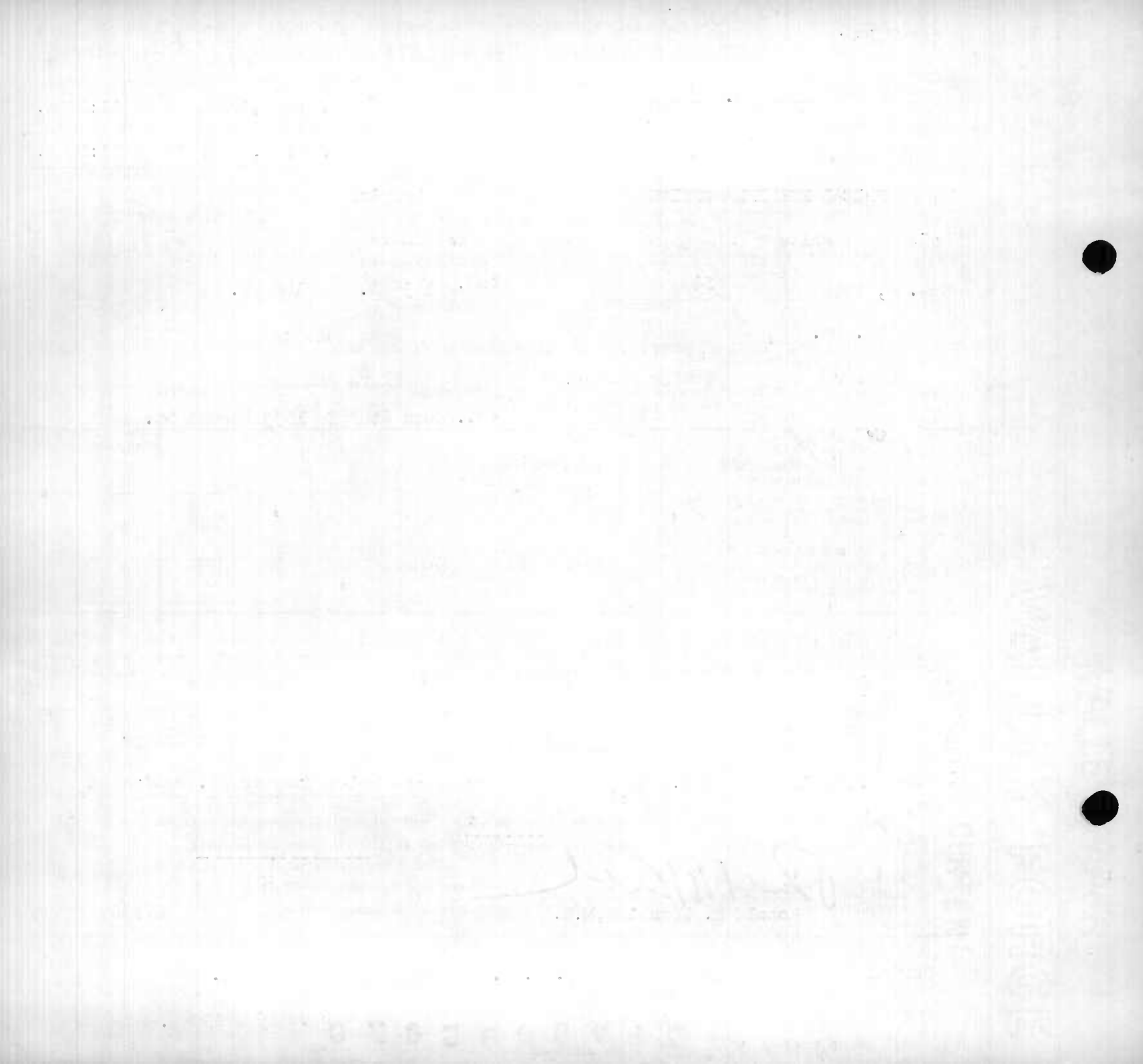
| | | | | | | | |
|--|-------------------------|---|--|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) WILLIAM J. HELEINE | | | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 8, 1969 | | Hour 11:30 A. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
60 MEDICAL EXAMINER OFFICE | | | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 8, 1969 | | Hour 11:30 A. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 23-03 | | | | | | | |
| 6. SEX
Male | 7. RACE
White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH
Oct. 6, 1914 | | 10. AGE (In years lost birthday) 54 | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | | E. STREET AND NUMBER
Unk. 1735 S. Charles St. | |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | 13. FATHER'S NAME
John Heleine | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | |
| 15. MOTHER'S MAIDEN NAME
Clara Unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes # 2 | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS
Mrs. Jean Stumpf 1633 Locust St. | |
| 19. 2984X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | CAUSE OF DEATH
Drowning
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | | |
| | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No)
yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Harbor | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Hanover Street Bridge | | | |
| 22D. TIME OF INJURY (APPROX.) June 1969 | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Found below Hanover St. Bridge | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
6/9/69 | | | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6 11 1969 | | 24C. NAME of CEMETERY or CREMATORY
Balto. U. S. National | | 24D. LOCATION (City, town, or county) (State)
Balto. Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
Mc Cully | | 25C. FUNERAL DIRECTOR ADDRESS
130 E. Fort Av | | | |



1

M-600 69 5880 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

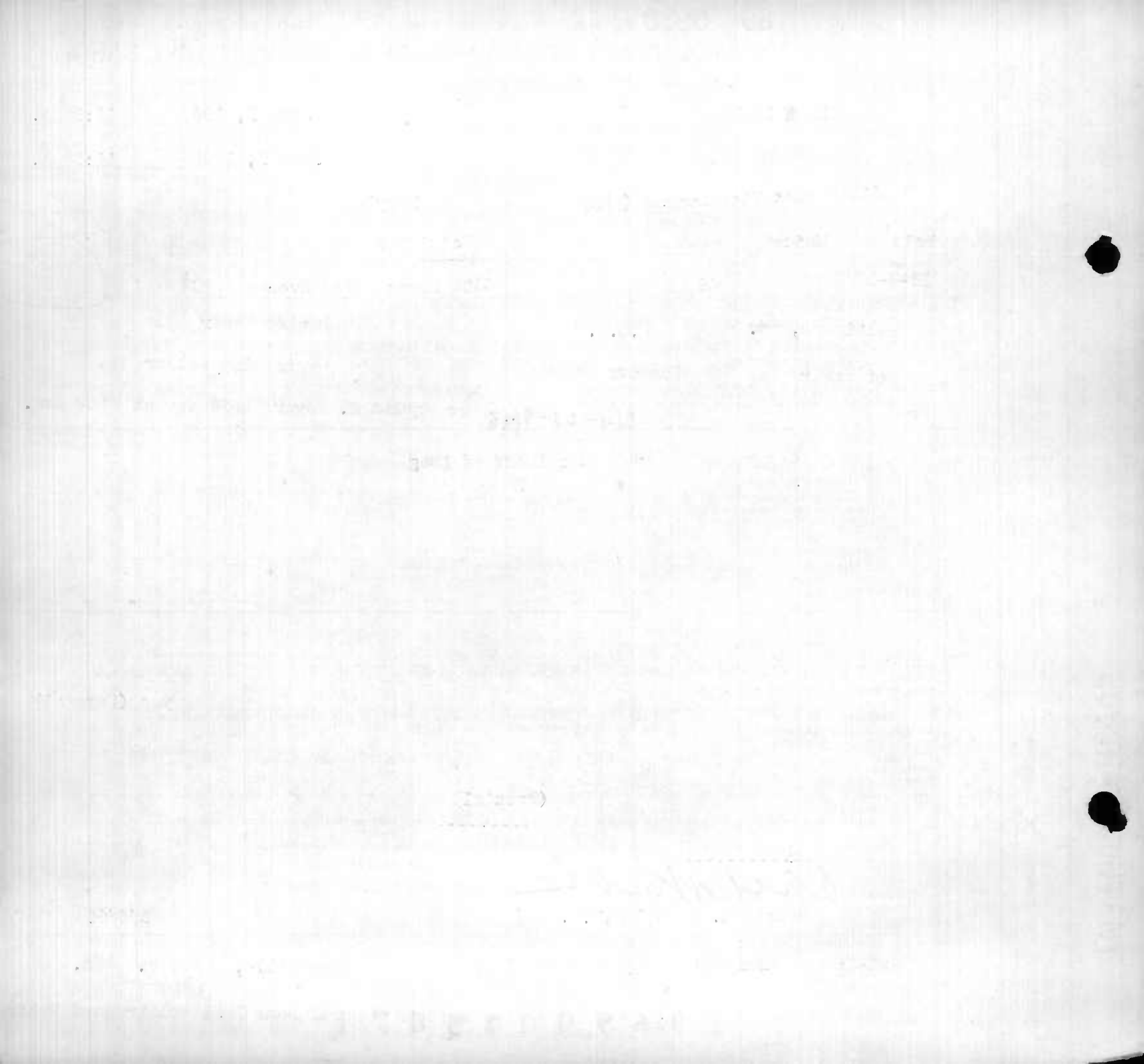
REG. NO. 69 5880

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
HENRY MEYER | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 5, 1969
Hour 11:30 AM | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 4428 Forest View Avenue (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 5, 1969 11:30 AM | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
11-7-1902 | | 10. AGE (In years lost birthday)
66 | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret Baker | | 14B. KIND OF BUSINESS OR INDUSTRY
Koester Bakery | |
| 15. MOTHER'S MAIDEN NAME
Catherine Weller | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 17. SOCIAL SECURITY NO.
214-61-9148 | | 18. INFORMANT
Mrs Amalia A. Meyer | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of Lung | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 21. AUTOPSY? (Yes or No)
yes (Partial) | | 22. DATE OF OPERATION
2 | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 24. LOCATION (City, town, or county) (State)
Parkville, Balto. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-9-1969 | |
| 24C. NAME OF CEMETERY or CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Parkville, Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
Robert E. Galt, M.D. | |
| 25C. FUNERAL DIRECTOR
Lessah Funeral Home | | 25D. ADDRESS
7401 Belair Road 21236 | |

VS 151-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| 0-165 69 5881 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5881 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | ANNE C. O'BRIEN | | June 5 1969 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | 5. M. STATE | |
| CERTIFICATE AMENDED
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)
6304 OLD HARFORD RD
BALTIMORE MD 21206 | | 6. CITY OR TOWN
BALTIMORE | | 7. COUNTY
BALTIMORE | |
| 8. INSIDE CITY LIMITS? | | 9. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTH PLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Telephone Operator State of Md | | Maryland | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| John A Zerhusen | | Barbara Ellen Brock | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 212-26-7775 | | John O'Brien 6405 ALTA AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 3 mos. | |
| ANTECEDENT CAUSES | | (B) CARCINOMA PANCREAS | | 6+ mos. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 5 1969 to June 6 1969, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) We (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| FRANK T. KASIK | | 6/7/69 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| FRANK T. KASIK | | 9005 HARFORD RD BALTO | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 6-9-1969 | | Holy Redeemer | |
| 24D. LOCATION | | 24E. CITY, TOWN, or county | | 24F. STATE | |
| BALTIMORE | | BALTIMORE | | MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 10 1969 | | Robert E. Taylor | | CHAS T. EVANS | |
| | | | | 8802 Harford Rd | |

VS 153 6-25-69 M.H.

VS 153 6-25-69 M.H.

VS 153 6-25-69 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

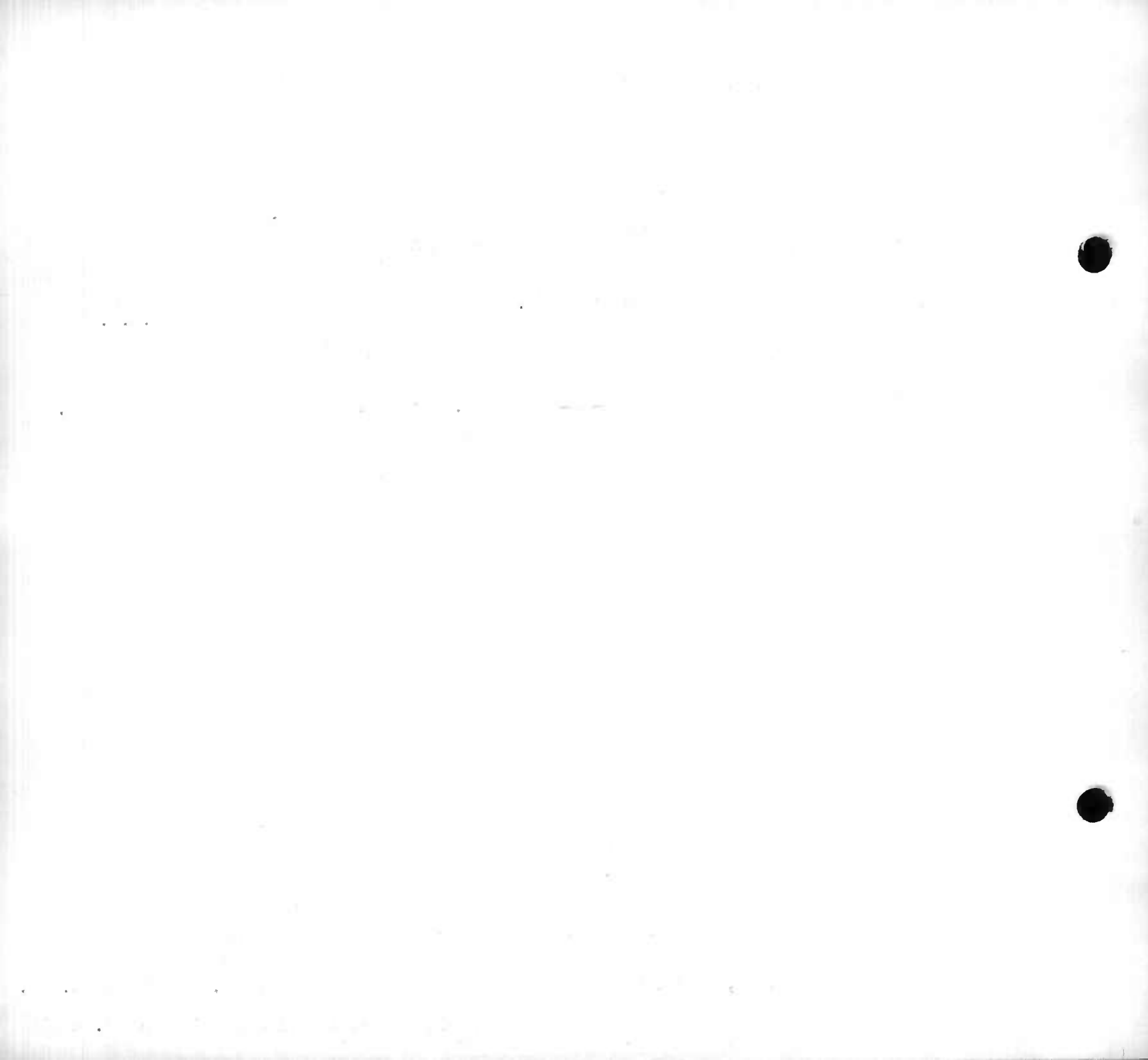
| 7-580 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5882 | |
|---|---------------------|--|--|--|--|
| BIRTH NO. 69 5882 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) WILLIAM THOMAS | | 2. DATE AND HOUR OF DEATH
6/6/69 13:10 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
48 MARLAND GEN. HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY 27-34 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
48 MARLAND GEN. HOSPITAL | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
5414 BIDDISON AVE. 21206 | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2-3-92 | 9. AGE (in years last birthday)
77 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bottling Dept. | | 10B. KIND OF BUSINESS OR INDUSTRY
National Brewery | | 11. BIRTHPLACE (State or foreign country)
MD. Baltimore | |
| 13. FATHER'S NAME
HENRY V. THOMAS | | 14. MOTHER'S MAIDEN NAME
MOLLIE WEINIGER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
26-03-8006 | | 17. INFORMANT
HELEN ZEUP | |
| | | | | ADDRESS
SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)
CHRONIC OBSTRUCTIVE LUNG DISEASE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
FEVERISH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
PNEUMONIA | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF:
DIABETES MELLITUS | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF:
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/27/69 to 6/6/69 that (I) (we) last saw the deceased alive on 6/6/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
E. M. DE LOS SANTOS JR. MD. | | | | 23B. DATE SIGNED
6/6/69 | |
| 23C. PHYSICIAN'S NAME (Type)
E. M. DE LOS SANTOS JR. MD. | | | | 23D. ADDRESS
M & A | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-9-1969 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | |
| 24D. LOCATION
Baltimore City MD | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
0 0 0 0 0 0 | | 25C. FUNERAL DIRECTOR
Lossain Funeral Home 7401 Belair Rd 21236 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| M-240 | | 69 5883 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | |
|--|--------------|---|--|---|--|--|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | | | | REG. NO. 69 5883 | |
| 1. NAME OF DECEASED
(Type or Print) | | CHESTER MUN MICHAEL | | | | 2. DATE AND HOUR OF DEATH
6/6/69 11 45 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | | | 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | | |
| UNION MEMORIAL HOSPITAL | | RANDALLSTOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | E. STREET AND NUMBER | | | | | |
| | | 9021 Allenswood Rd. | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
06-14-10 | | 9. AGE (in years last birthday)
58 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| MAIL CLERK | | Equitable Trust Co. | | MARYLAND | | AMERICAN | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | |
| MICHAELS (D) | | MARY ANNE COLEMAN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | 217-01-9647 | | Mrs. Helen H. Michael | | 9021 Allenswood Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Peritonitis, perforated ulcer of stomach | | | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | D.H. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (this hospital) attended the deceased from | | 19 69 to 6/6 | | 19 69 | | | |
| that (I) last saw the deceased alive on | | 6/6/69 | | and that (in my) opinion death occurred on the date | | | |
| and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | | | |
| Luis CINTADO MD | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | | | |
| Luis CINTADO MD | | UNION MEMORIAL HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | June 9, 69 | | Lorraine Park Cemetery | | Windsor Mill Rd. Baltimore Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUN 10 1969 | | Robert E. J. J. MD | | Loring Byers | | Chapel 8728 Liberty Rd. 21133 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| J-630 69 5884 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5884 | |
|--|---------------------|--|-----------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Skwirut John Michael</u> | | 2. DATE AND HOUR OF DEATH
<u>6/8/69</u> <u>8:14 AM</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>38 University Hospital</u> | | A. STATE
<u>Md.</u> | | B. COUNTY
<u>26-36</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>6616 Marne Ave.</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2/5/62</u> | 9. AGE (In years last birthday)
<u>7</u> | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Child</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | |
| 13. FATHER'S NAME
<u>Louis Skwirut</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary H. Fronckowski</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>-</u> | | 16. SOCIAL SECURITY NO.
<u>-</u> | | 17. INFORMANT ADDRESS
<u>Mr. Louis R. Skwirut, 6616 Marne Ave</u> | |
| 18. <u>746.21</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Myocardial infarction</u>
(B) <u>Coronary heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>Tetralogy</u>
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>16/6/69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Tetralogy</u> | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/11/69</u> 19 <u>69</u> to <u>6/8/69</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/8/69</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>J. M. Juanteguy MD</u> | | DEGREE
<u>MD</u> | | 23B. DATE SIGNED
<u>6/8/69</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
<u>University Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/11/69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Holy Rosary</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 10 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>M. S. Sadowski & Sons, 1808 Eastern Ave</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 69 5885 | |
|---|---|---|---|--|---|
| BIRTH NO. D-320 | | | | | |
| 1. NAME OF DECEASED
(Type or Print) EMILIE A. DOETSCH | | | 2. DATE AND HOUR OF DEATH
June 8, 1969 M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 ENCORE HOUSE
218 Ridgewood Road, City. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 27-13 | | |
| | | | C. CITY OR TOWN
City of Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
14 Merrymount Road, Roland Park, City 10 | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 30, 1882 | 9. AGE (In years last birthday)
86 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired - Lawyer | | 10B. KIND OF BUSINESS OR INDUSTRY
Law | 11. BIRTHPLACE (State or foreign country)
Baltimore City, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Louis John Doetsch | | | 14. MOTHER'S MAIDEN NAME
Johanna Pohl | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | 17. INFORMANT: sister ADDRESS
Louisa Doetsch, 4401 Roland Av., City 10 | | |
| 18. 4/10/91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

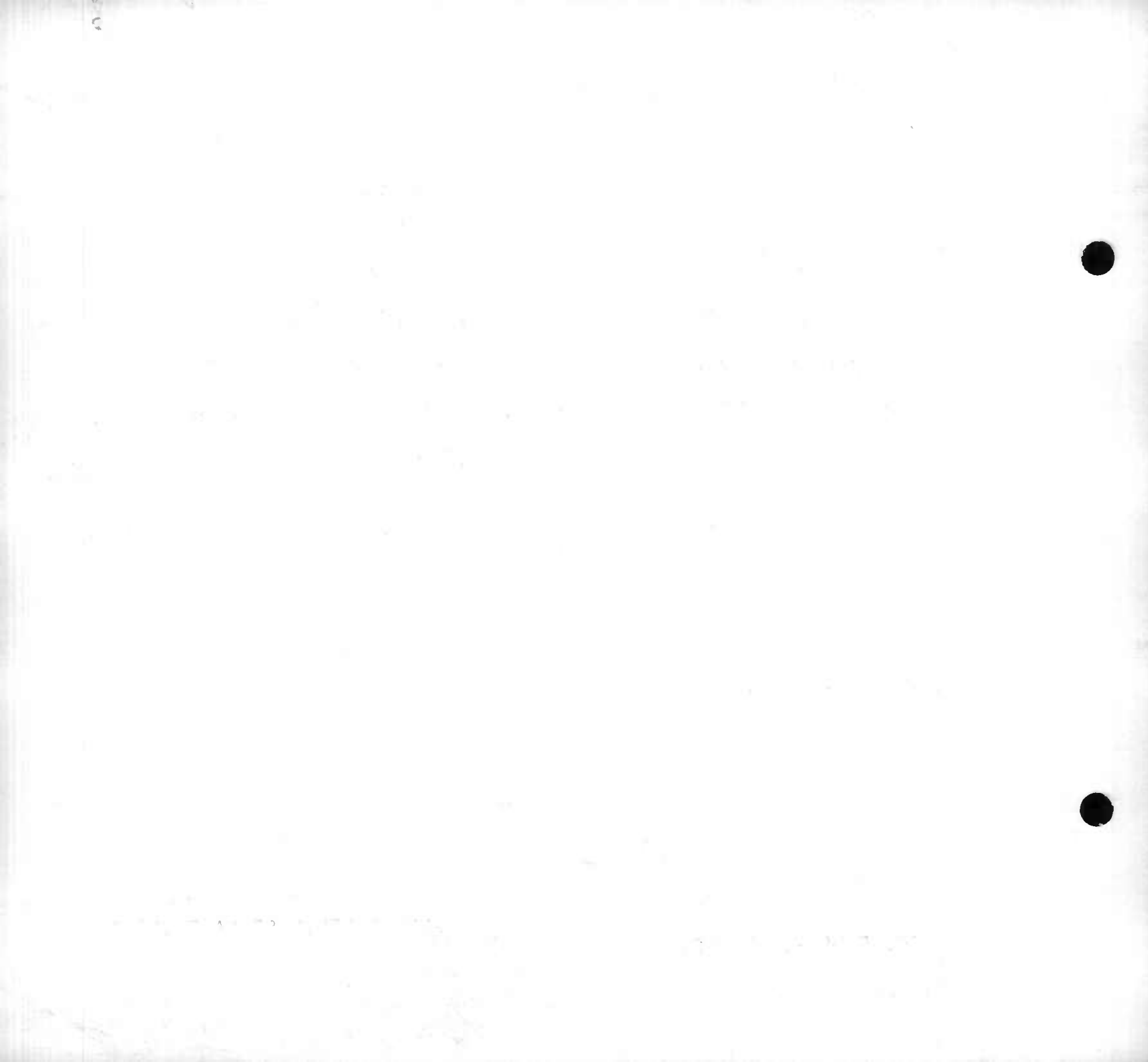
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Paralytic Myocardial Infarction
(B) Generalized & cerebral arteriosclerosis
(C) _____ | | | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 50 to June 1969 , that (I) (we) last saw the deceased alive on June 2 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Walter B. Buck | | | | 23B. DATE SIGNED
June 9, 68 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
STUART & MOWEN CO. 108 W. North Av., City 1 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
CREMATION | | 24B. DATE
6/9/69 | | 24C. NAME of CEMETERY or CREMATORY
Green Mount Cemetery | |
| 24D. LOCATION
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
STUART & MOWEN CO. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

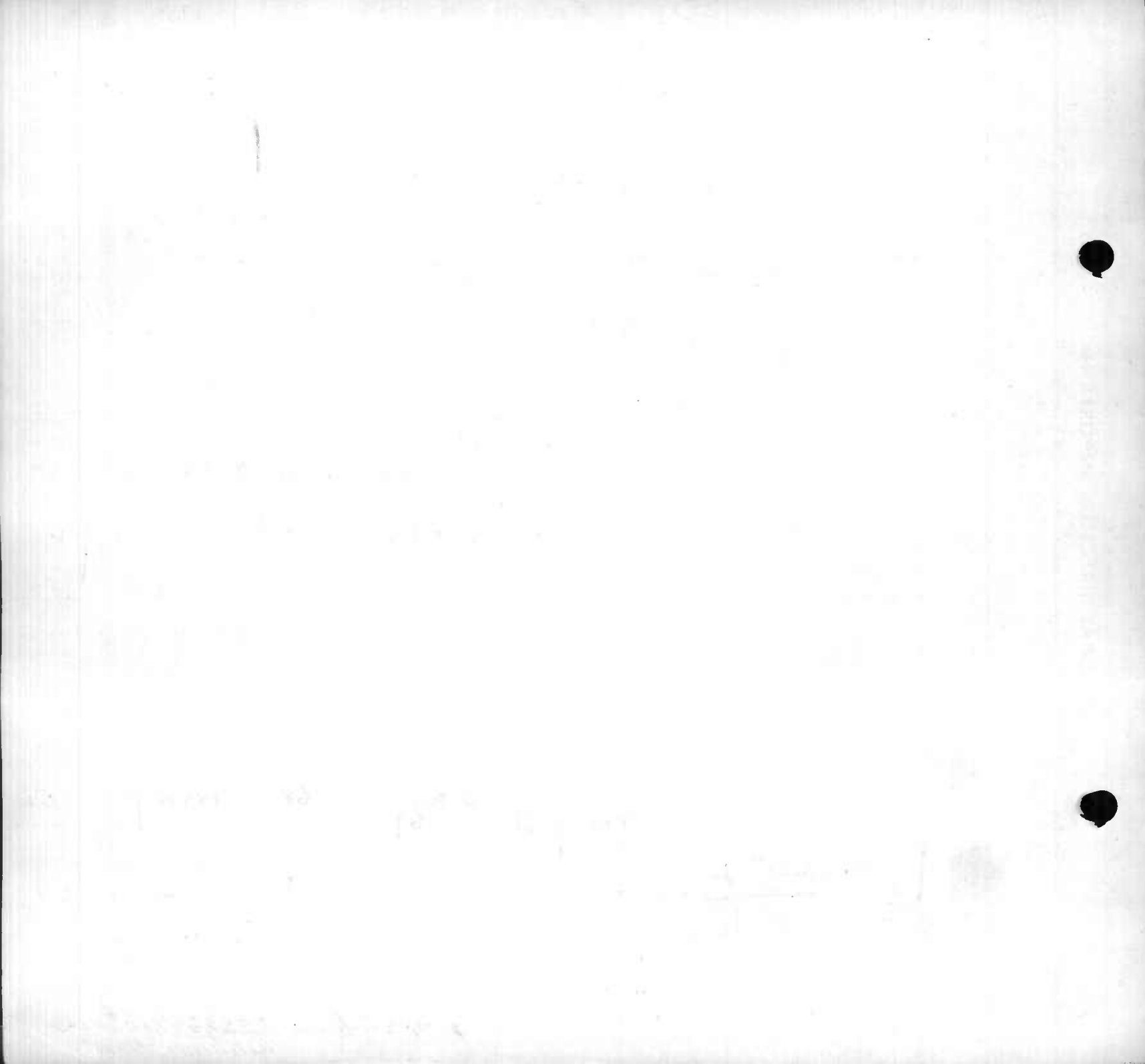
| C-620 | | 69 5886 | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 69 5886 | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) MRS CROUSE JACQUELINE K. | | | |
| 2. DATE AND HOUR OF DEATH
June 7th 1969 6:45 p.m. | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
The Union Memorial Hospital | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Southern Baltimore | | | | C. CITY OR TOWN GREEN ARM | | | |
| D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | E. STREET AND NUMBER WOODCREST | | | |
| 5. SEX Female | | 6. RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-29-1926 | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years last birthday) 42 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (State or foreign country) N. Carolina | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY own home | | 12. CITIZEN OF WHAT COUNTRY? American | | 13. FATHER'S NAME WARRIOR KING | |
| 14. MOTHER'S MAIDEN NAME JULIA JONES | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 245-24-8839 | | 17. INFORMANT Husband ADDRESS same | |
| 18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE Subarachnoid hemorrhage 6/1/69 | | | |
| ANTECEDENT CAUSES | | | | (B) hypertensive cardiovascular disease 6/1/69 | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) _____ | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 6/7/1969 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED unconscious | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1st 19 69 to June 7th 19 69 that (I) (we) last saw the deceased alive on June 7th 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Pius Y. Cho | | | | 23B. DATE SIGNED June 7th 1969 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. PIUS Y. CHO MD. | | | | 23D. ADDRESS UNION MEM. HOSP. BALTO. MD. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 6/11/69 | | 24C. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park Balto. Md. | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 10 1969 | | 25B. NAME OF REGISTRAR Robert E. Faber, Jr. | | 25C. FUNERAL DIRECTOR Joseph H. Hine | | ADDRESS 7541 Pelham Rd Balto. Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|---------|--|------------------|--|------------------------------|
| G-514 | | 69 5888 | | 69 5888 | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| WILLIE GAMBLE | | 6/1/69 # 1115A | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| Bon Secours Hospital | | Md | | 20-04 | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Balto | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 137 Willard St | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| M | C | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 3-20-07 | 62 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| FARMER | | | | S.C. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| JOSEPH | | ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 249-266-2242 | | Bernard Hardy | |
| | | | | ADDRESS | |
| | | | | Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 2 hrs. | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | 1 yr. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 19 68 to May 19 69, that (I) (we) last saw the deceased alive on May 31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Wm. E. Beaven | | 6/1/69 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Wm. E. Beaven M.D. | | Bon Secours Emerg Rm | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 6-7-1969 | | Mt. Auburn Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Westport (Baltimore) Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 10 1969 | | P. E. E. Jones M.D. | | J. P. Jones 2223 N. North Ave. Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>69 5889</u> |
|---|--|--|--|---|
| BIRTH NO. <u>19</u> | | 1. NAME OF DECEASED
(Type or Print) <u>Bessie Hayes Ruckle</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 2. DATE AND HOUR OF DEATH
<u>6-9-69</u> <u>6:40</u> M. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>University of Md Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>1 Balto. Co.</u> | | |
| 5. SEX <u>F</u> | | 6. RACE <u>W.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>H-W.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
<u>8-22-94</u> |
| 13. FATHER'S NAME
<u>John Hayes (Fetting)</u> | | 14. MOTHER'S MAIDEN NAME
<u>Kate</u> | | 9. AGE (in years last birthday)
<u>74</u> |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>215-24-2990</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> |
| 17. INFORMANT
<u>Mr. John Fetting, Jr., 314 N. Charles St.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Pneumonia</u> | | | | <u>1 day</u> |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Pneumonia</u> | | | | <u>2 wk.</u> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
<u>6-9-69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (N) (this hospital) attended the deceased from <u>6-3</u> 19 <u>69</u> to <u>6-9</u> 19 <u>69</u> that (N) (we) last saw the deceased alive on <u>6-9</u> 19 <u>69</u> and that (N) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (N) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Ruth Ann Przybysz, M.D.</u> | | | | 23B. DATE SIGNED
<u>6-9-69</u> |
| 23C. PHYSICIAN'S NAME (Type)
<u>RUTH ANN PRZYBYSZ, M.D.</u> | | 23D. ADDRESS
<u>UNIVERSITY OF MD. HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/11/69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Druid Ridge Cemetery</u> |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 10 1969</u> | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, MD.</u> | | 25C. FUNERAL DIRECTOR
<u>Witzke 4101 Edmondson Ave., 21229</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|--|--|--|
| CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) NEARY MR. Harry | | June 7, 1969 8 ⁰⁵ P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

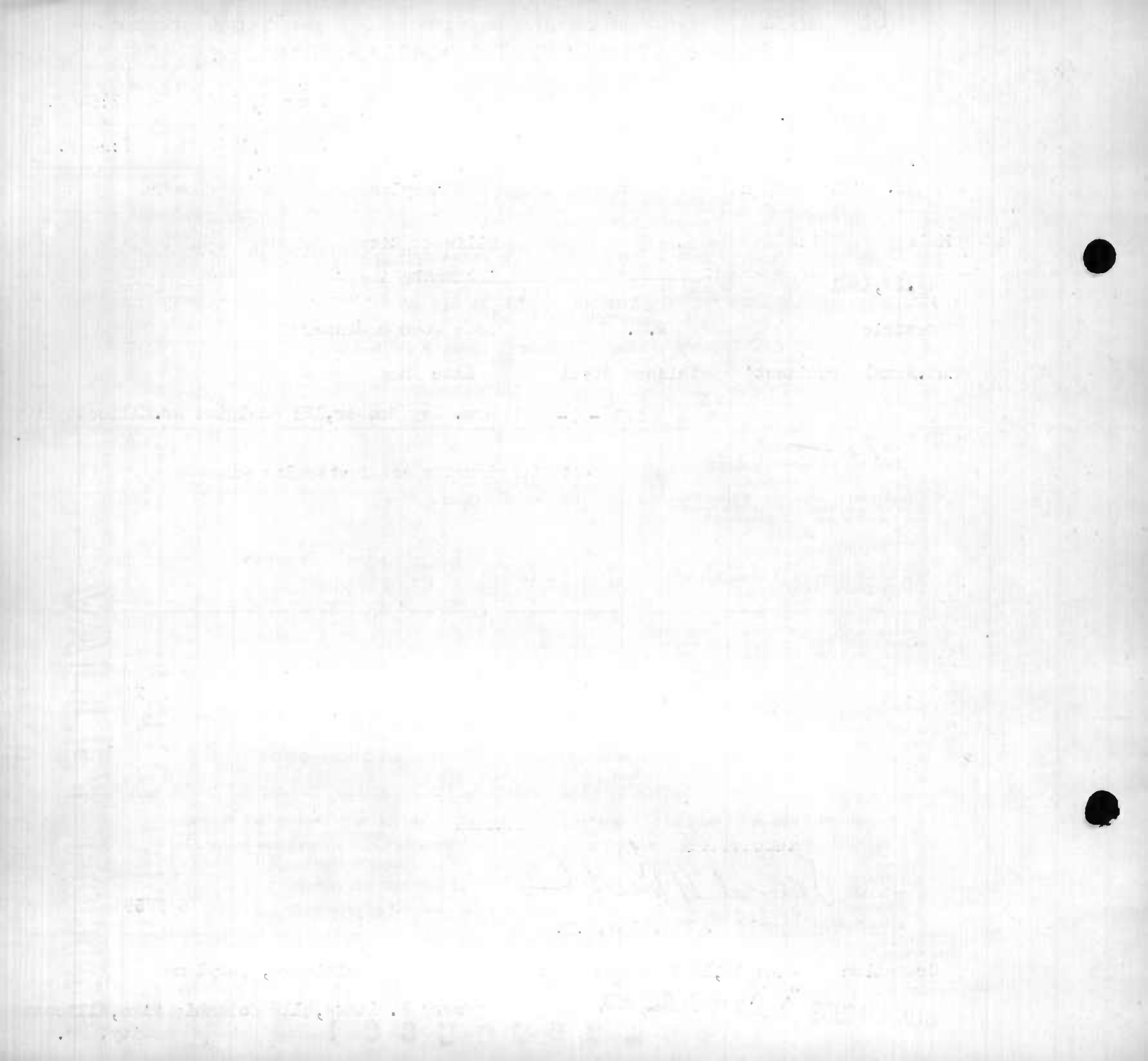
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
34 Bon Secours Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md.
B. COUNTY 20-02 | |
| 5. SEX Male | | 6. RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/10/1899 | |
| 9. AGE (In years last birthday) 69 yrs | | 10. AGE (In years last birthday) 69 yrs | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Superintendent - Reviere, Brass | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
John T. Neary | |
| 14. MOTHER'S MAIDEN NAME
Sara | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
215-10-0620 | | 17. INFORMANT
Mrs. Catherine Neary, 2530 W. Fayette St. | |
| 18. CAUSE OF DEATH
412.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Generalized arteriosclerosis, marked, with coronary, left iliac, splenic involvement. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A)
Malnutrition | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 6. 5 19 69 to 6. 7 19 69 , that (1) (we) last saw the deceased alive on 6. 7 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
U. Sangkum | | 23B. DATE SIGNED
6. 7. 69 | |
| 23C. PHYSICIAN'S NAME (Type)
U. SANGKUM | | 23D. ADDRESS
BSH | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/10/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mt. Olivet Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | |
| 25C. FUNERAL DIRECTOR
Witzke | | 25D. ADDRESS
4101 Edmondson Ave., 21229 | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

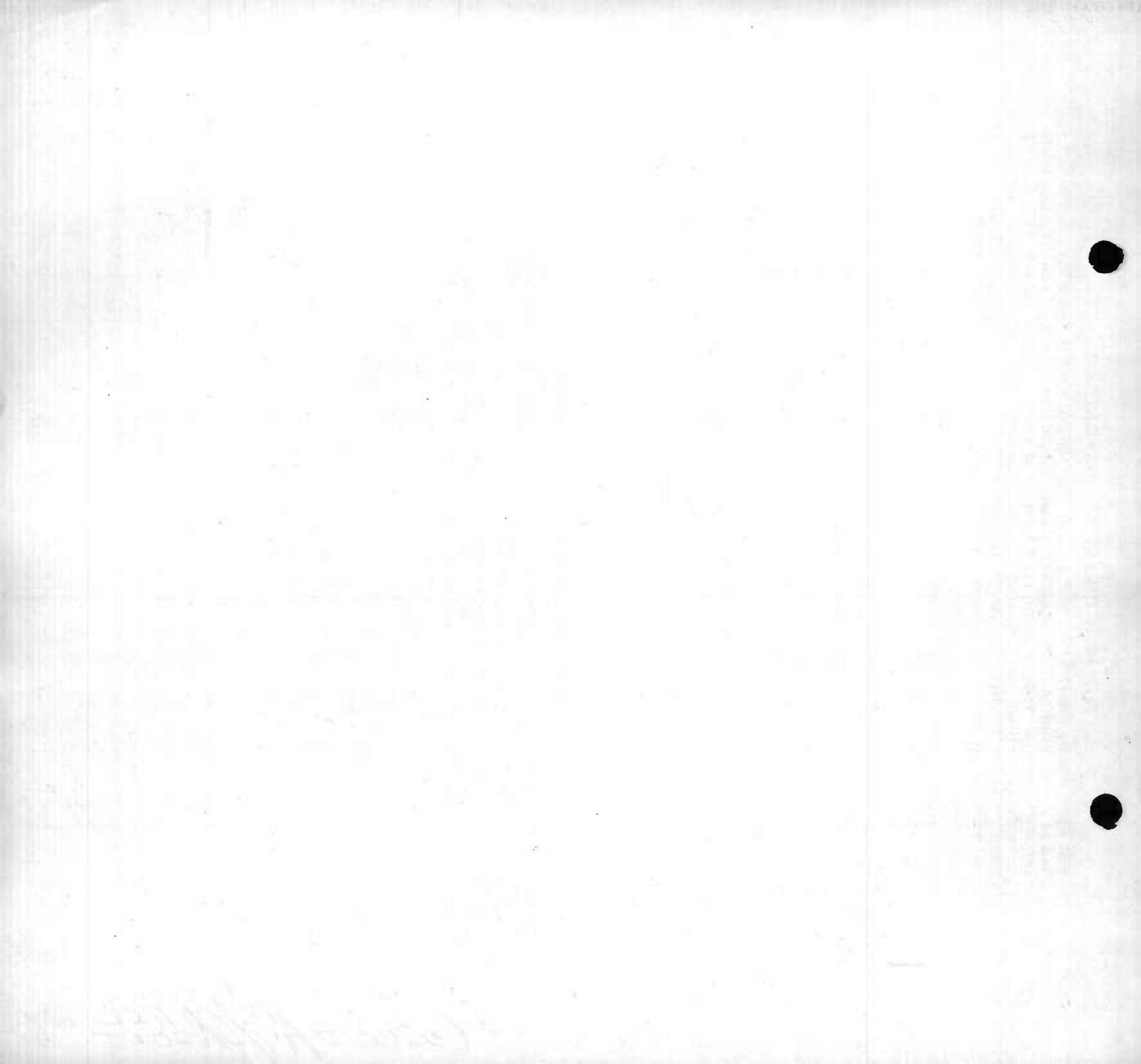
| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
KARL A. HAUSER | | 2. DATE OF DEATH
Known <input type="checkbox"/> Estimated <input type="checkbox"/>
Month June , Day 6 , Year 1969
Hour 7:54 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
10 ST. AGNES HOSPITAL | | 3. DATE PRONOUNCED DEAD
Month June , Day 6 , Year 1969
Hour 7:54 P. M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Howard | | 6. SEX Male 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
Aug. 27, 1901 | | 10. AGE (In years lost birthday) 67 | |
| 11. BIRTHPLACE (State or foreign country)
Austria | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Naval Architect | | 14B. KIND OF BUSINESS OR INDUSTRY
Bethlehem Steel | |
| 15. MOTHER'S MAIDEN NAME
Late Anna | | 13. FATHER'S NAME
Late Joseph Hauser | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO.
216-03-0030 | |
| 18. INFORMANT
Mrs. Kay Hauser, 123 McAlpine Dr. | | ADDRESS
Ellicott City | |
| 19. 412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Md. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Ronald N. Kornblum M.D.
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.
DATE SIGNED 6/7/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
June 10, 1969 | |
| 24C. NAME OF CEMETERY or CREMATORY
Loudon Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
Harry H. Witzke | | ADDRESS
4112 Columbia Pike, Ellicott City, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|---|-------------------------|---|--|---|---|
| 69 5892 | | 69 5892 | | 69 5892 | |
| 1. NAME OF DECEASED
(Type or Print) HOWARD E. WOOD | | 2. DATE AND HOUR OF DEATH
June 8 - 1969 1:30 P. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND , WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Baltimore Md B. COUNTY 15-10 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
4009 Liberty Heights Ave Baltimore Md | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
4009 Liberty Heights Ave | | | | | |
| 5. SEX
Male | 6. RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct 18 1879 | 9. AGE (in years last birthday)
89 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
GARDENER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore Md | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
George Thomas Wood | | 14. MOTHER'S MAIDEN NAME
Emma Taylor | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, for or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
212-10-2826 | | 17. INFORMANT
Helen Gibson 3502 Grantley Rd | |
| 18. 412.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic Cardiovascular Disease | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Cardiovascular Disease | | (B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1969 to June 8 1969 , that (I) (we) last saw the deceased alive on June 6 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Louis T. Lavy | | 23B. DATE SIGNED
June 9 1969 | | 23C. PHYSICIAN'S NAME (Type)
LOUIS T. LAVY | |
| 23D. ADDRESS
3502 W. ROGERS AVE Baltimore Md | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
6/11/69 | | 24C. NAME OF CEMETERY OR CREMATORY
McCalver Cem. Arne, Azundel Co | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor Md | | 25C. FUNERAL DIRECTOR
C. Oscar A. Johnson | | | |

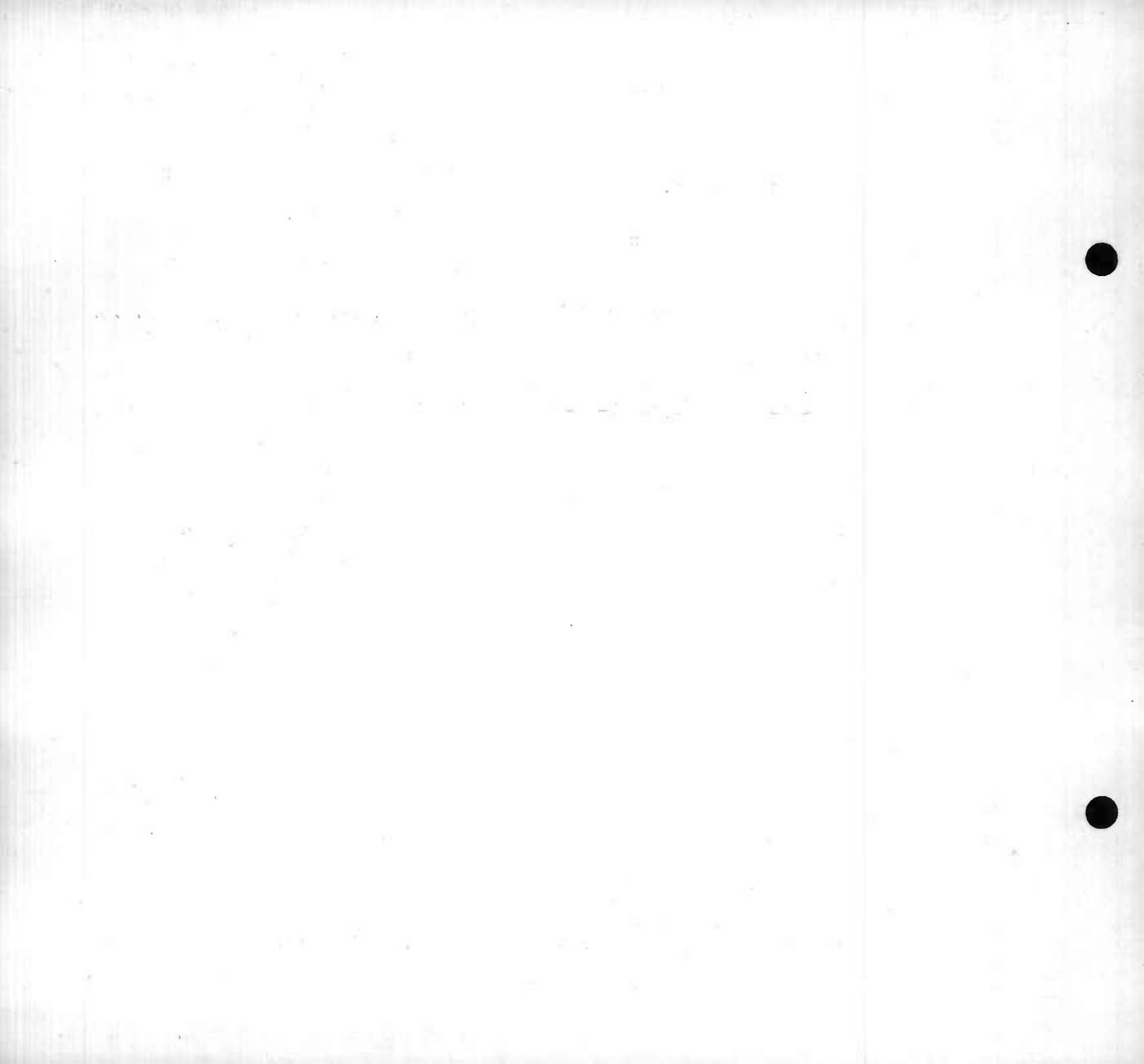


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 5893 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. 69 5893 | |
|--|-------------------------|---|--|---|---|
| 1. NAME OF DECEASED
(Type or Print) Phillip Richardson | | | 2. DATE AND HOUR OF DEATH
6/5/69 12:35 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
802 Mc Kean Ave. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 16-04
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 802 Mc Kean Ave. | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/23/06 | 9. AGE (In years last birthday)
63 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook | | 10B. KIND OF BUSINESS OR INDUSTRY
Merchant Club | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
? Richardson | | |
| 14. MOTHER'S MAIDEN NAME
Doritha ? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 8-13-43 to 12-13-45 | | |
| 16. SOCIAL SECURITY NO.
8-13-43 to 12-13-45 | | | 17. INFORMANT
Ruth Richardson | | |
| 18. ADDRESS
802 Mc Kean Ave. | | | 19. CAUSE OF DEATH
410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CORONARY Thrombosis
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
ARTERIOSCLEROTIC HEART DISEASE
CONGESTIVE HEART FAILURE | | |
| 20. DATE OF OPERATION | | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22. AUTOPSY? (Yes or No) | |
| 23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 26. TIME OF INJURY (APPROX.) | | 27. INJURY OCCURRED | | 28. HOW DID INJURY OCCUR? | |
| 29. I certify that (I) (this hospital) attended the deceased from 1/25/69 to 6/5/69 | | 30. that (I) (we) last saw the deceased alive on 6/5/69 | | 31. and that in (my) (our) opinion death occurred on the date 6/5/69 | |
| 32. and have read from the causes stated above, (I) (We) (did) (did not) view the body after death. | | 33. SIGNATURE
Gilbert Banfield | | 34. DATE SIGNED
6/6/69 | |
| 35. PHYSICIAN'S NAME (Type)
Gilbert Banfield | | 36. M.D. DEGREE
M.D. | | 37. ADDRESS
722 N. Fulton Ave. | |
| 38. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 39. DATE
6/9/69 | | 40. NAME OF CEMETERY or CREMATORY
Carver Memorial Park | |
| 41. LOCATION
Laurel Maryland | | 42. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 43. NAME OF REGISTRAR
Robert E. Fisher | |
| 44. FUNERAL DIRECTOR
Dutter Funeral Home | | 45. ADDRESS
3035 W. North Ave. | | 46. DATE
6/6/69 | |



FUNERAL DIRECTOR: IMPORTANT

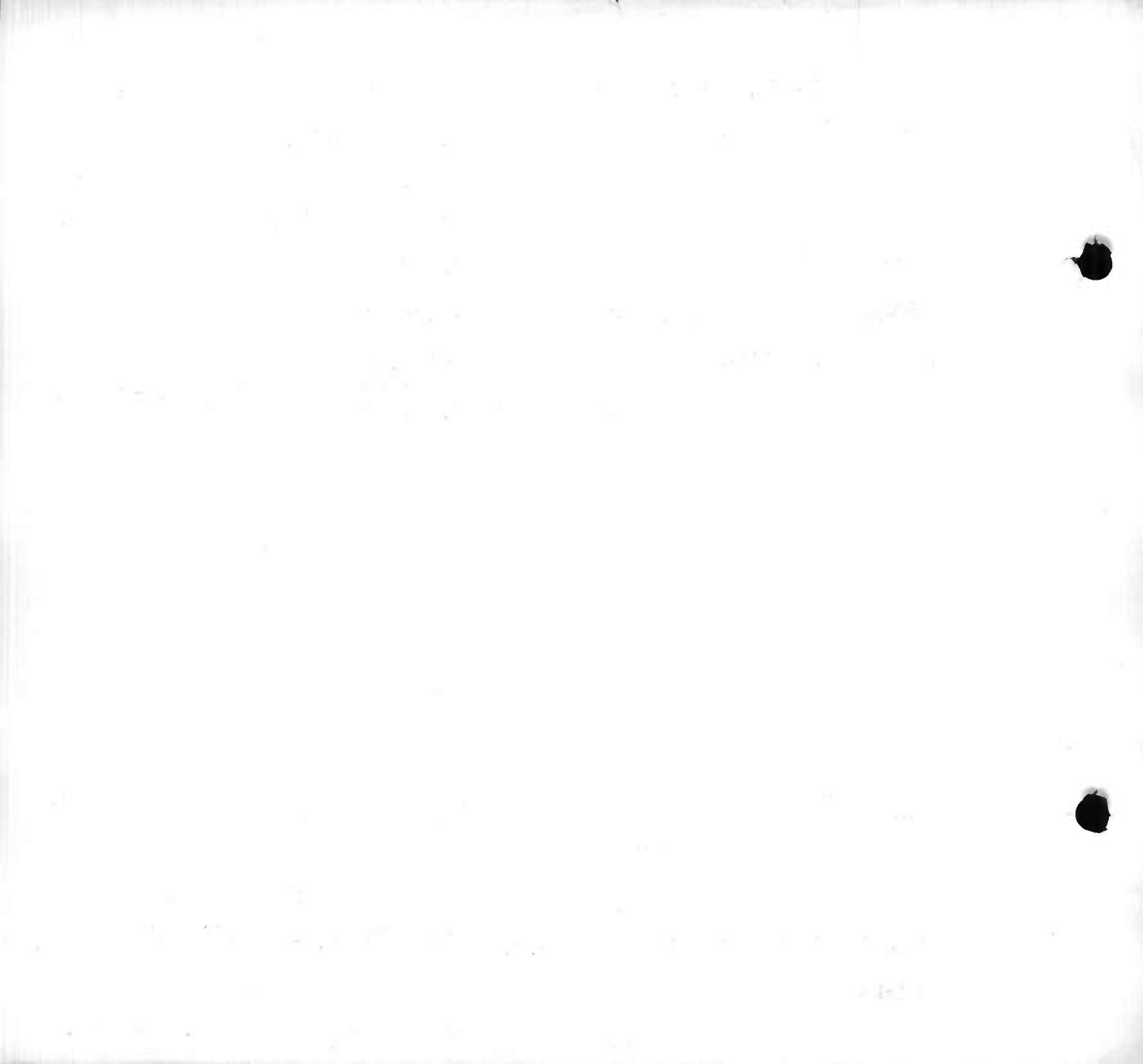
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | | |
|--|---------------------|---|-------------------------------------|---|----------------------------|--|-----------------------------|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) ROOSEVELT McLain | | | | 2. DATE AND HOUR OF DEATH
June 5, 1969 1 45 PM. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
UNIVERSITY HOSP. | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE SPRINGFIELD B. COUNTY HOSP. | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNIVERSITY HOSP. | | | | C. CITY OR TOWN
BALTIMORE | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER
2207 W. LAFAYETTE AVE | | | | | | | | | | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/13/08 | 9. AGE (in years last birthday)
60 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
COOK | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Bickford's Restaurant | | | | 11. BIRTHPLACE (State or foreign country)
NORTH CAROLINA | | | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | 13. FATHER'S NAME
JAMES Mc CLAIN | | | | 14. MOTHER'S MAIDEN NAME
VIOLA Atwater | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
216-143243 | | | | 17. INFORMANT
MRS Elizabeth Batten | | | |
| 18. 5-69-41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Peritonitis | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Perforation of Small Int. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| (C) | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION
5/29/69 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cholecystectomy | | | | 20A. AUTOPSY? (Yes or No) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/19/69 19 to 6/5 19 69 that (I) (we) last saw the deceased alive on 6/5 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
VICENTE R. CARAG J.D.M.D. | | | | | | | | 23B. DATE SIGNED
6/5/69. | | | |
| 23C. PHYSICIAN'S NAME (Type)
Vicente R. Carag Jr. M.D. | | | | | | | | 23D. ADDRESS
University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | 24B. DATE
6-9-69 | | | | 24C. NAME OF CEMETERY OR CREMATORY
WESTERN STAR Cemetery | | | |
| 24D. LOCATION
Baltimore County, Md | | | | | | | | | | | |
| 25A. DATE RECD BY HEALTH DEPT.
JUN 10 1969 | | | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | | | 25C. FUNERAL DIRECTOR
Herbert B. Nuttall | | | |
| | | | | | | | | ADDRESS
3085 W. NORTH AVE. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | | | | | | |
|---|-------------------------|---|---|--|---|--|--|--|--|
| BIRTH NO.
69 5895 | | REC'D NO. 69 5895 | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) MATTHEWS, JAMES ALBERT | | | | | 2. DATE AND HOUR OF DEATH
6/7/69 9:00 P.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
ST. AGNES HOSPITAL
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
40 | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)
A. STATE MD. B. COUNTY BALTO. Co.
C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 26 SHIPLEY AVE. | | | | |
| 5. SEX
MALE | 6. RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/23/92 | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Gardner | | | 10B. KIND OF BUSINESS OR INDUSTRY
Pvt. Family | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U S A | | |
| 13. FATHER'S NAME
CHARLES H. MATTHEWS | | | 14. MOTHER'S MAIDEN NAME
ADAMS, MARY | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
216 14 3243 | | 17. INFORMANT ADDRESS
CATON & WILKENS AVE. - BALTO. MD
3 ST. AGNES HOSPITAL RCDS | | | | |
| 18. 250.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) IMMEDIATE CAUSE Irreversible Electrolyte Imbalance
DUE TO, OR AS A CONSEQUENCE OF:
(B) Diabetic ketoacidosis, coma
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
6/7/69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that X (this hospital) attended the deceased from 5/2/71 19 69 to 6/7/71 19 69 that X (we) last saw the deceased alive on 6/7/71 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Gloria G. Boonswang M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
6/7/69 | | |
| 23C. PHYSICIAN'S NAME (Type)
DR. GLORIA BOONSWANG | | | | | 23D. ADDRESS
BALTO., MD. ST AGNES HOSP. - WILKENS & CATON AVE. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/11/69 | | 24C. NAME of CEMETERY or CREMATORY
Western Star Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, County Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 10 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Nutter Funeral Home 3035 W. North Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 69 5896 | |
|--|---------|--|-----------------------------------|---|---|--|-------------------------|
| N-365 69 5896 | | | | BIRTH NO. Virginia | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| LINDA NIEDERWEMMER | | | | June 6, 1969 10:57 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| THE JOHNS HOPKINS HOSPITAL
33 BALTIMORE, MD 21205 | | | | MARYLAND Baltimore 53-00 | | | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | BALTIMORE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 7012 BEECH AVE | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days | 12. Under 24 Hrs. Hours |
| FEMALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8-22-66 | 2 1/2 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | |
| CHILD | | | NONE | | VIRGINIA | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | |
| DONALD SMITH | | | LINDA PEARL NIEDERWEMMER | | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| No | | | NONE | | JOSIE NIEDERWEMMER 7012 BEECH AVE | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | Sepsis 3 days | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Leukemia (acute stem cell) 11 mos | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/3/69 19 to 6/6/69 19 that (I) last saw the deceased alive on June 6 19 69 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Michael A. Simmons, MD | | | | 6/6/69 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| MICHAEL A. SIMMONS M.D. | | | | THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 6-10-69 | | GARDEN OF FAITH CEMETERY | | BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUN 10 1969 | | J. E. Fisher, MD | | Dipper Bros. Inc | | 7110 BELAIR ROAD | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5897 | |
|--|-------------------------------|--|--|---|---|
| E-425 69 5897 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. <i>md.</i> | | 1. NAME OF DECEASED (Type or Print) TAMMY ELGIN | | | |
| 2. DATE AND HOUR OF DEATH June 8, 1969 4:35 A.M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE | |
| | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER 1155 CIRCLE DRIVE | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-9-69 | 9. AGE (in years last birthday) 3 MO |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Marian Maeser ADDRESS 1155 Circle Dr. Balto, Md. 21227 | |
| 18. 7466 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Cardiac Arrest | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Respiratory Arrest | | 5 minutes | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF:
Congenital Heart Disease | | 3 mo | |
| | | (C) Aorta to Pulmonary Artery Shunt for Triangular Atrium | | 6/8/69 | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 3/6/7/69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRIANGULAR ATROSLA | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/8/69 to 6/8 19 69 and that (I) (we) last saw the deceased alive on 6/8/69 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Brent L. Horsley, M.D. | | DEGREE MD | | 23B. DATE SIGNED 6/8/69 | |
| 23C. PHYSICIAN'S NAME (Type) BRENT L. HORSLEY, M.D. | | DEGREE MD | | 23D. ADDRESS The Johns Hopkins Hospital, Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE Junell, 1969 | 24C. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Marriottsville, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 10 1969 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Harry B. Witke ADDRESS 4112 Columbia Pike, Ellicott | |

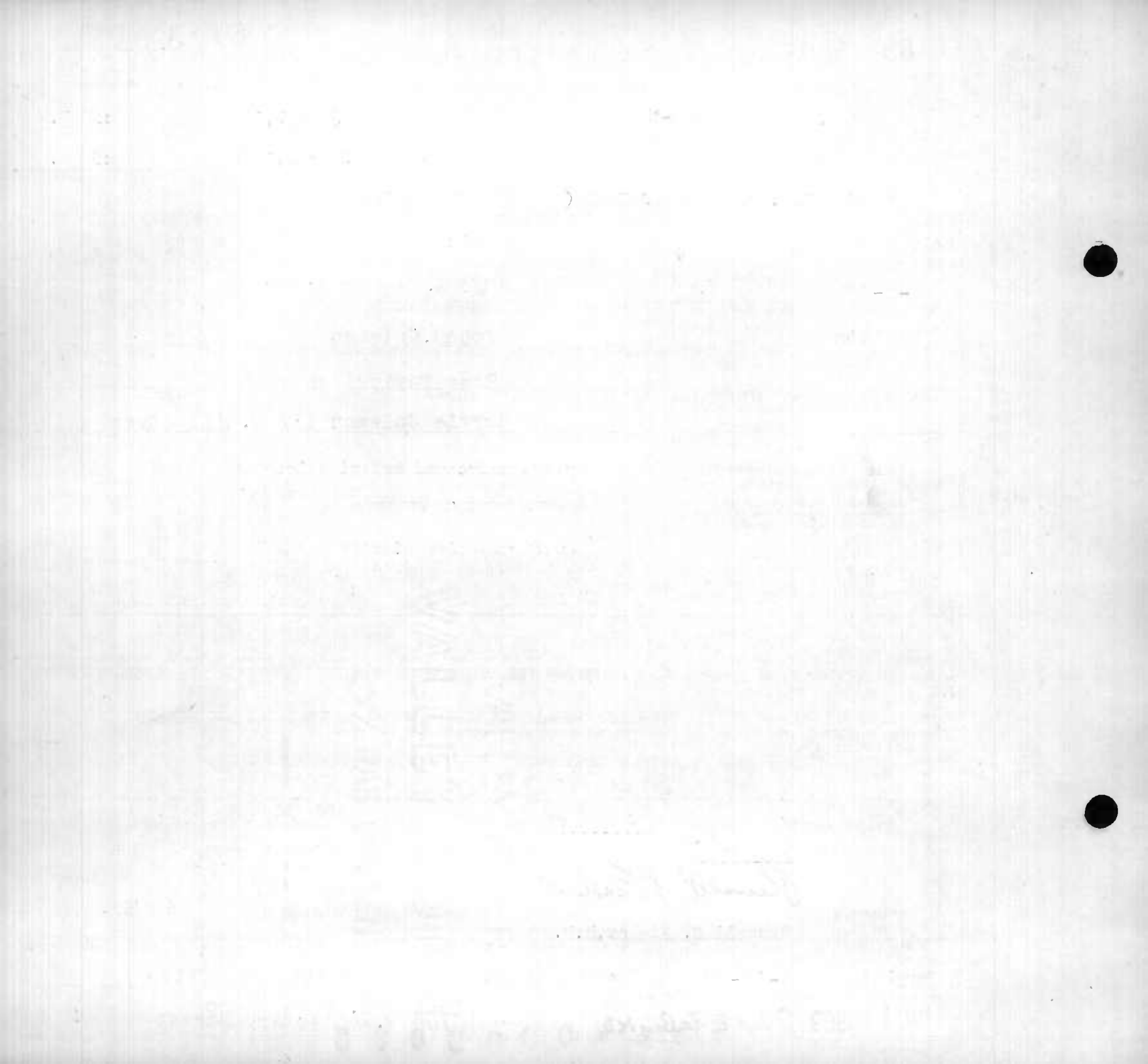


69 5898 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5898 REG. NO.

BIRTH NO.

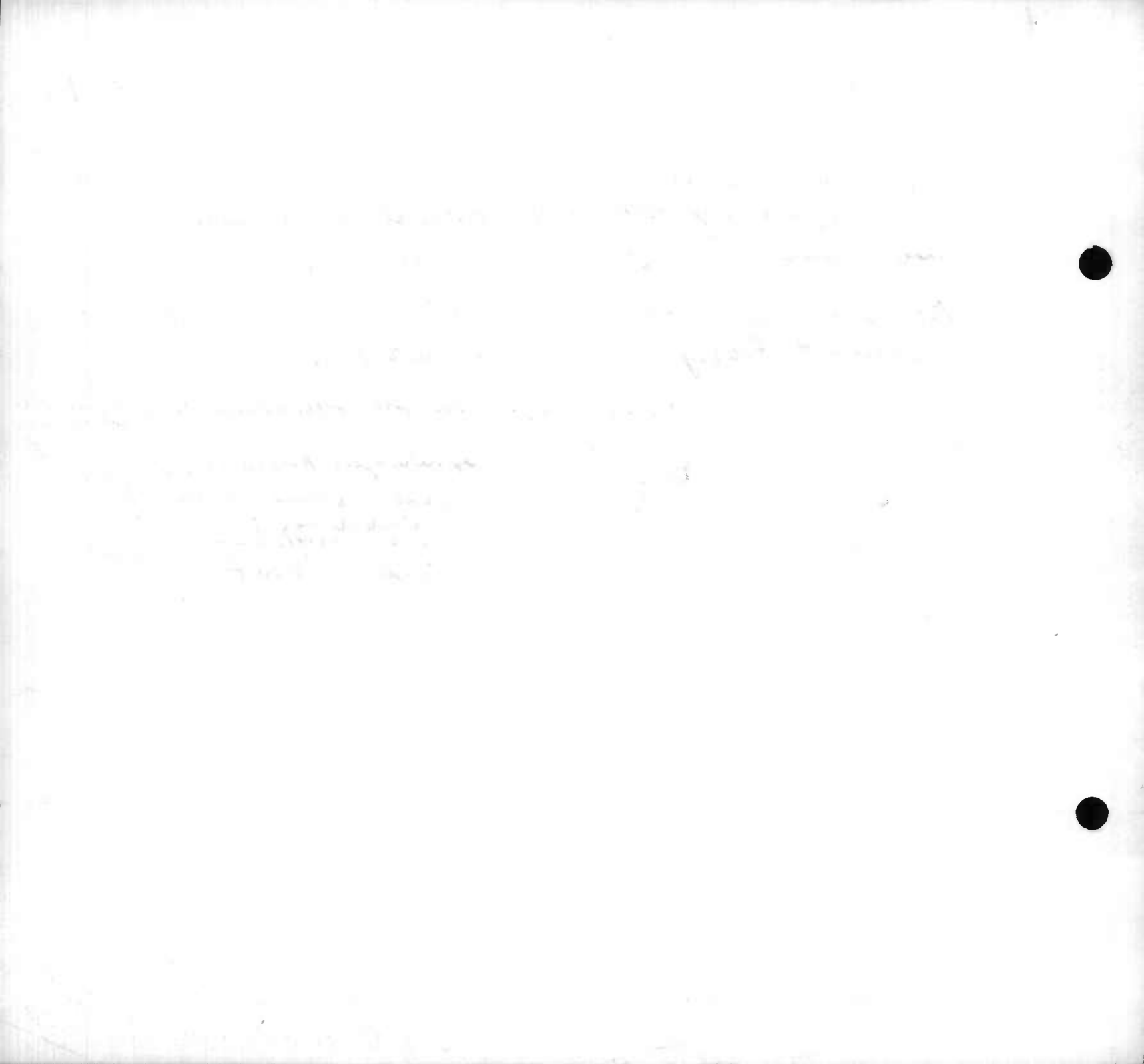
| | | | |
|--|-------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print)
JOHN COLEMAN -H | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 7, 1969
Hour 8:50 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
SOUTH BALTO. GENERAL HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 7, 1969
Hour 8:50 P. M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 23-01 | | C. CITY OR TOWN
Baltimore
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX
Male | 7. RACE
Negro | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
6-5-05 | | 10. AGE (In years last birthday) 65
If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
John H. Coleman | | 14. STREET AND NUMBER
105 W. Hamburg Street | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
L | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME
Rosa Taylor | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Carrie Coleman
ADDRESS
117 W. Hill Street | |
| 19. 412.2
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Hypertensive and Arteriosclerotic
(A) IMMEDIATE CAUSE
XXXXXX XXXXXXXX XXXXXXXX
Cardiovascular Disease
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
No | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23.
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Russell S. Fisher M.D.
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.
DATE SIGNED 6/8/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-II-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mount Auburn | | 24D. LOCATION (City, town, or county) (State)
Baltimore City | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
Isaiah L. Brown & Son | | 25D. ADDRESS
108 W. Montgomery Street | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

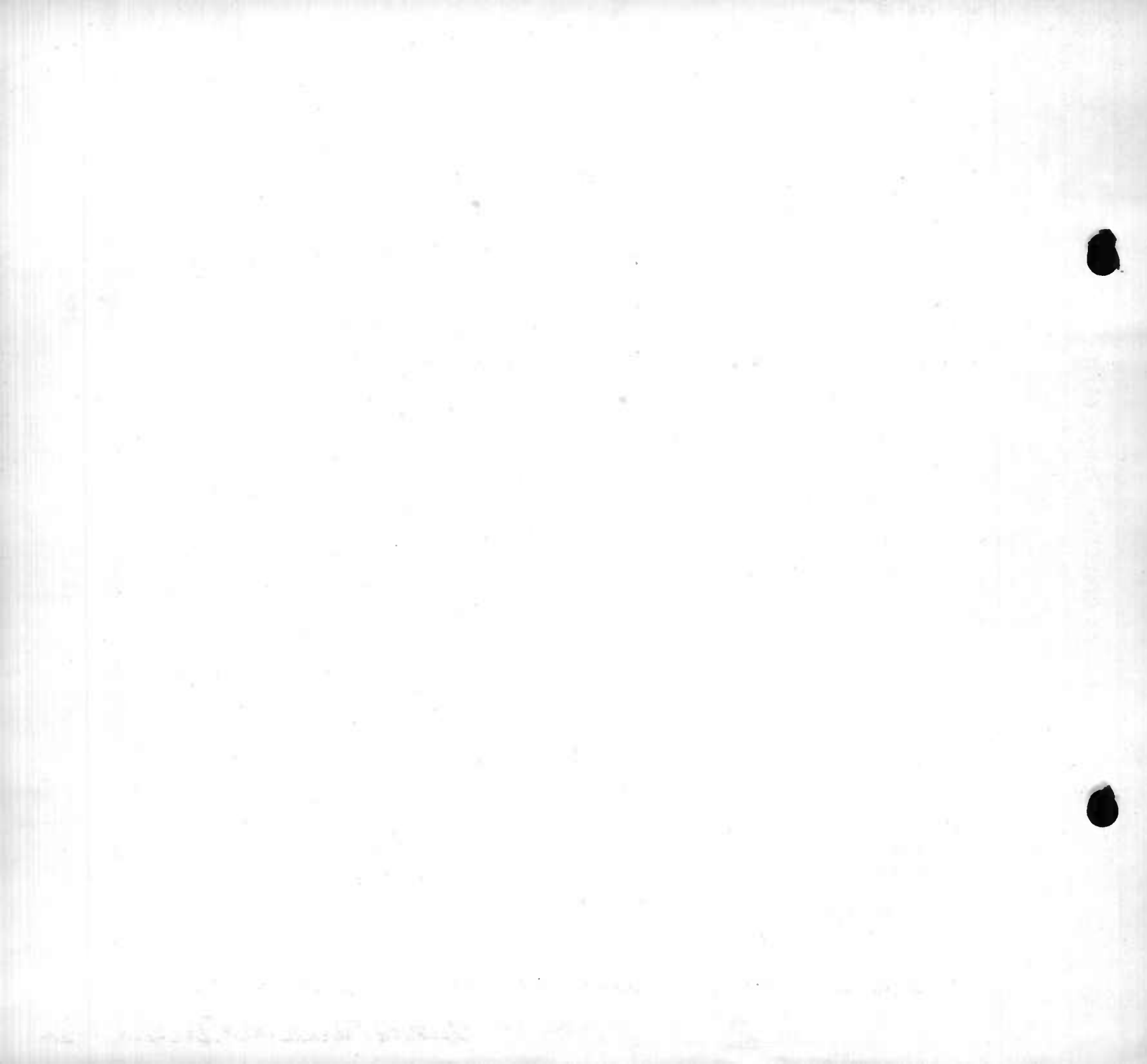
| | | | | | |
|---|-------------------------|---|-------------------------------------|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) FADELEY Mr. Charles | | 2. DATE AND HOUR OF DEATH
6.3.1969 1.30 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE MD. B. COUNTY CECIL CO. | | 5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Church Home and Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
100 N Broad Way Baltimore MD. 21231 | | E. STREET AND NUMBER
Broad St. Perryville, MD. | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1.1.1888 | 9. AGE (In years last birthday)
81 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Maintenance Man | | 10B. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (State or foreign country)
MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
William H. Fadeley | | 14. MOTHER'S MAIDEN NAME
Elizabeth Price | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216 01 7795 | | 17. INFORMANT
Mrs. Ann Fellen Baum | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Generalized Arteriosclerosis | | 19. CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
myocardial infarction
(B) DUE TO, OR AS A CONSEQUENCE OF:
Coronary artery disease
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hrs. yrs. min. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-28 19 69 to 6-3 19 69 that (I) (we) last saw the deceased alive on 6-3 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
James M. D. | | 23B. DATE SIGNED
6-3-69 | | 23C. PHYSICIAN'S NAME (Type)
Jose F. Mier Jr. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
6-6-1969 | | 24C. NAME OF CEMETERY OR CREMATORY
Principio Cemetery | |
| 24D. LOCATION (City, town or county) (State)
Perryville, Cecil, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | 25B. NAME OF REGISTRAR
Robert E. Faber, M.D. | |
| 25C. FUNERAL DIRECTOR
Stacy & Sons & Son Perryville MD | | 25D. ADDRESS
100 N. Broadway | | 25E. ADDRESS
21331 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5900 |
|---|---------------------|--|--|--|
| BIRTH NO. 69 5900 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) ELLEN BEARD | | 2. DATE AND HOUR OF DEATH
June 4, 1969 11⁵⁵ P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Harboring Nursing & Convalescent Center | | A. STATE Maryland B. COUNTY BALTO. CO. | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 90 | | E. STREET AND NUMBER
8201 Long Point Road | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 22, 1882 | 9. AGE (In years last birthday)
86 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
UTAH |
| 13. FATHER'S NAME
John Charles WORTH | | 14. MOTHER'S MAIDEN NAME
Mary Ferguson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
212-24-9376 | | 17. INFORMANT
Nursing Home Record - 1213 Light St. |
| 18. 412.4 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
Pulmonary edema
Cardiac Decompensation
1 1/2 hours
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
A.S.C.V. Disease
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Paralytic Disease | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 4/28 1969 to 6/4 1969 , that (I) (we) last saw the deceased alive on 6/4 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Joseph S. Blum | | 23B. DATE SIGNED
6/5/69 | | 23C. PHYSICIAN'S NAME (Type)
JOSEPH S. BLUM |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-9-69 | | 24C. NAME OF CEMETERY or CREMATORY
MORELAND MEM. PARK |
| 24D. LOCATION (City, town, or county) (State)
BALTO. CO., MD. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | |
| 25B. NAME OF REGISTRAR
James E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
U. S. BICENTENAL FEDERAL HOME, DONALD, MD. | | |



FUNERAL DIRECTOR: IMPORTANT

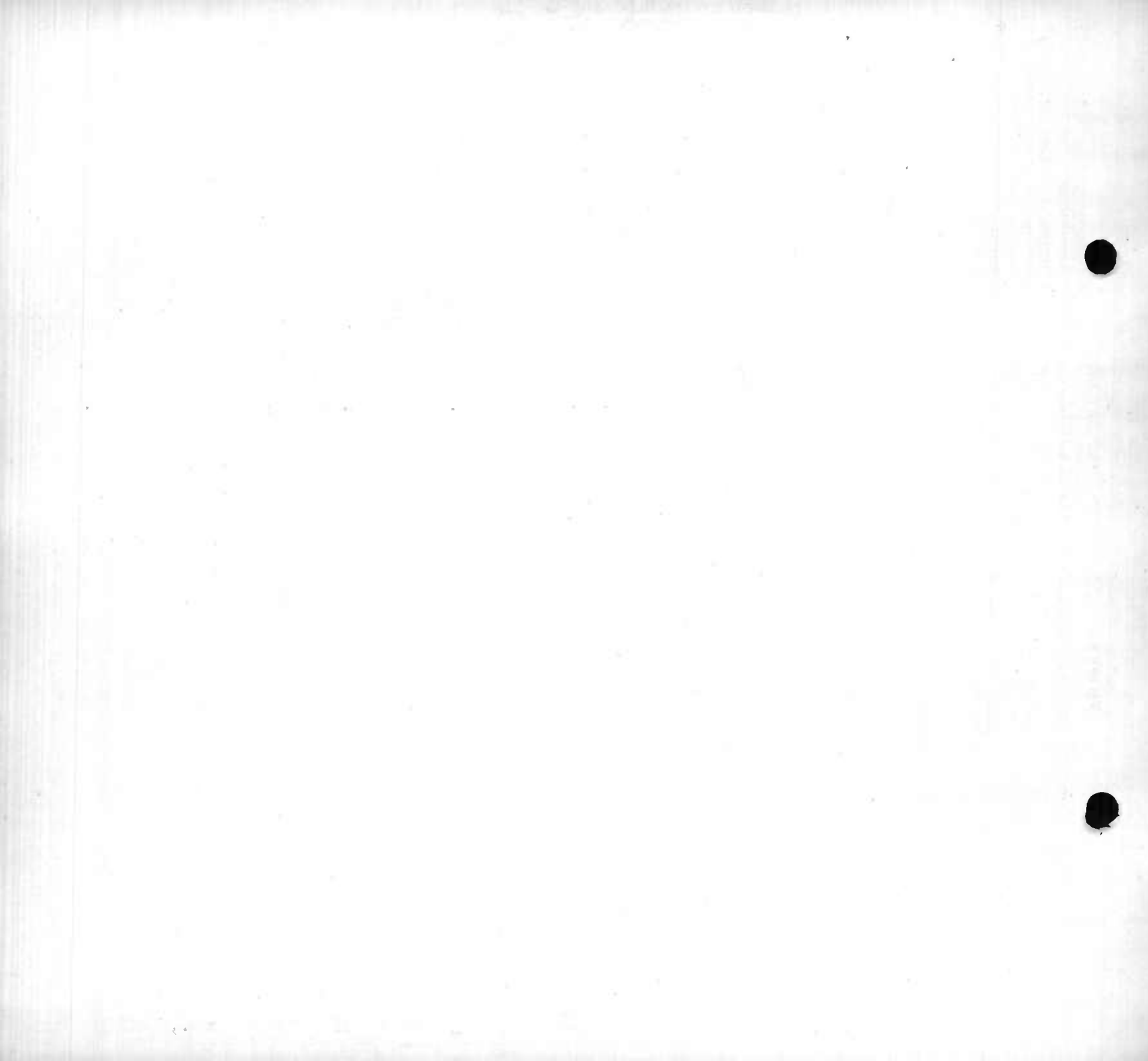
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 69 5901 |
|---|--|---|---|--|---------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | RICHARD H. FENNER | | 6-10-69 7:25 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
BON SECOUR HOSPITAL
34 | | | A. STATE
MD. BALTO. CO. 53-00 | | |
| | | | C. CITY OR TOWN
BALTO. | | |
| 5. SEX
M | | | 6. RACE
W | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
4-1-16 | | |
| 9. AGE (In years last birthday)
53 | | | 10. BIRTHPLACE (State or foreign country)
BALTO. | | |
| 11. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
GEORGE FENNER | | | 14. MOTHER'S MAIDEN NAME
ROSA YOUCHUM | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
216-01-3528 | | |
| 17. INFORMANT
Mrs. Richard H. Fenner, 621 Orpington Road | | | ADDRESS | | |
| 18. CAUSE OF DEATH | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: Respiratory acidosis, reversed old heart disease.</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: cor. diffuse. Emphysema (pulmonary) years. diffuse myocardial ischemia</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF: chronic H. pylori infection</p> </div> </div> | | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-12-1969 to 6-10-1969, that (I) (we) last saw the deceased alive on 6-10-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. D ARAB | | | | | |
| 23A. SIGNATURE
D ARAB (Daniel) | | | 23B. DATE SIGNED
6/10/69 | | |
| 23C. PHYSICIAN'S NAME (Type)
D ARAB | | | 23D. ADDRESS
Fredrick Ave 4921 Balto - se Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/13/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | | |
| 25B. NAME OF REGISTRAR
Witzke | | 25C. FUNERAL DIRECTOR
Edmondson Ave., 21229 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|--|--|--|---|--|
| 69 5902 | | 69 5902 | | 69 5902 | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| MARY BYRON | | 6-9-69 9:15p M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| | | MARYLAND | | 27-75 | |
| 16 LUTHERAN HOSPITAL OF MARYLAND | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | BALTO | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| F W | | W | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. UNDER 1 Yr. Months Ooys | |
| 7-9-38 | | 30 | | 11 Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Virginia | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Clark | | Elizabeth | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | 227-44-8364 | | Mr. Conrad H. Byron | |
| | | | | 5504 Midwood Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | CARCINOMA OF CERVIX | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| PULMONARY EMBOLISM | | | | | |
| (C)..... | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-7-19 69 to 6-9-19 69, that (I) (we) last saw the deceased alive on 6-9-19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Dahlia Quijada M.D. | | | | 6-9-69 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| DAHLIA QUIJADA | | LUTHERAN HOSP OF MARYLAND | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 6/13/69 | | Baltimore National | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 11 1969 | | Robert E. Haber, M.D. | | Vitzke, 2101 Edmondson Ave., 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5903 | |
|---|--|---|---|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 25 | | 69 5903 | | | |
| 1. NAME OF DECEASED
(Type or Print) LOUIS LASCOLA | | | 2. DATE AND HOUR OF DEATH
6/10/69 1:55 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
37 MERCY HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY 17-01 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
37 MERCY HOSPITAL | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX M 6. RACE W | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/5/09 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
GROVER | | | 10B. KIND OF BUSINESS OR INDUSTRY
own Business | | 9. AGE (In years last birthday)
60 |
| 13. FATHER'S NAME
Biaggio Lascola | | | 14. MOTHER'S MAIDEN NAME
ROSE SERIO | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
218-26-1006 | | 17. INFORMANT
Mrs. Louis J. Lascola, 410 N. Greene St. |
| 18. 4-10-91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Probable ACUTE MI extensive | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Coronary Artery Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 6-03-1969 to 6-10-1969 that we (we) last saw the deceased alive on 6-10-1969 and that my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
L. Manalo | | | 23B. DATE SIGNED
6-10-69 | | 23C. PHYSICIAN'S NAME (Type)
BAYANI L. MANALO, M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
6/13/69 | | 24C. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR, ADDRESS
Witzke, 4101 Edmondson Ave., 21229 |

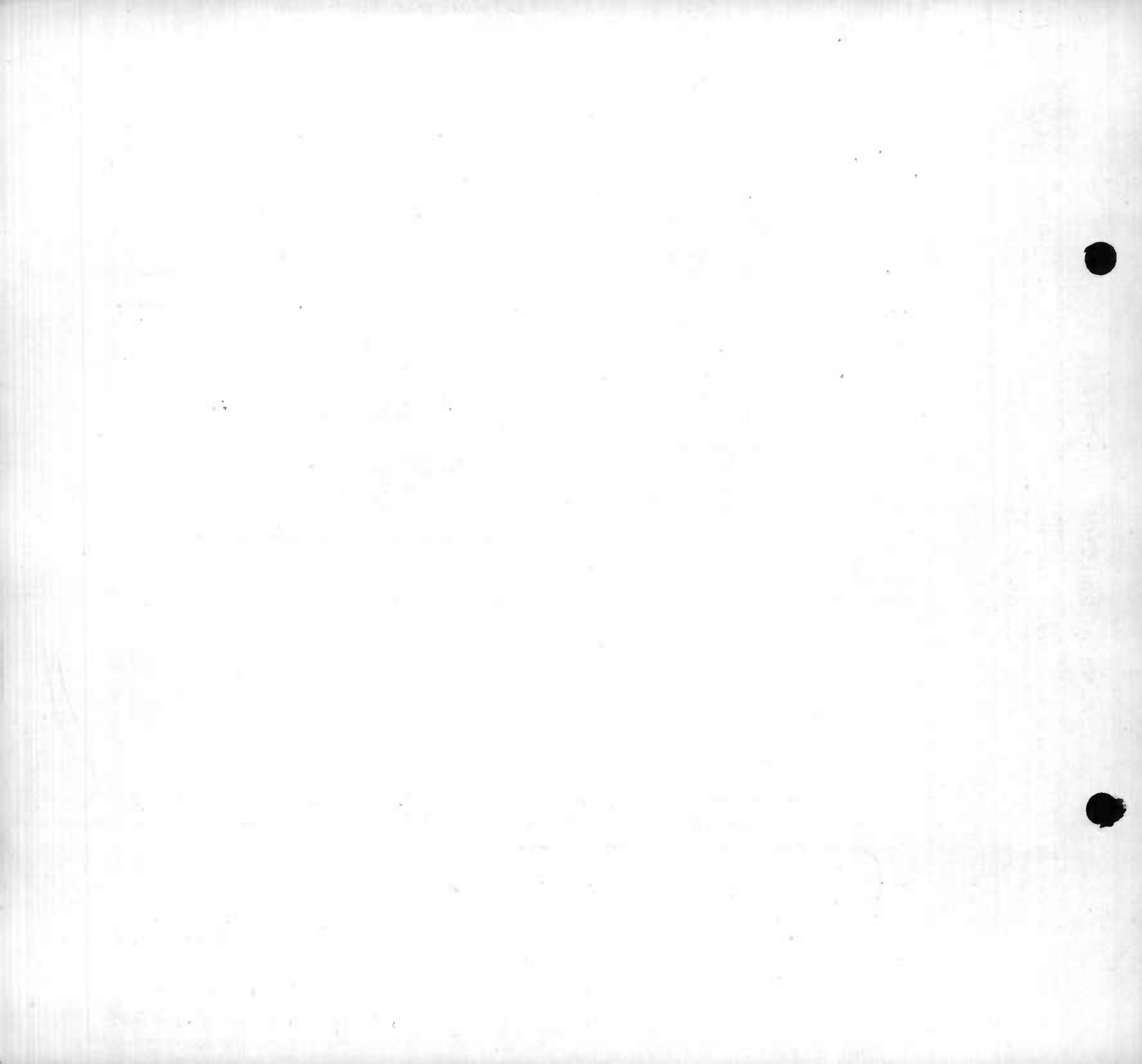
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5904</u> |
|--|--|--|---|---|
| BIRTH NO. <u>69 5904</u> | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Mollie Osing</u> | | 2. DATE AND HOUR OF DEATH
<u>June 9, 1969</u> <u>7:45 P.</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

<u>810 N. Woodington Road</u> | | C. CITY OR TOWN
<u>Balto</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>FEMALE</u> | | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>5-25-1885</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>---</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years lost birthday) <u>84</u> |
| 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>John Dieterich Osing</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Annie Osing</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mrs. Marjorie Zies</u> |
| ADDRESS
<u>810 N. Woodington Road</u> | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Apr 1, 1960</u> to <u>JUNE 9, 1969</u> , that (I) (was) lost saw the deceased alive on <u>June 9, 1969</u> and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Harry Knipp, M.D.</u> | | 23B. DATE SIGNED
<u>6-10-69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Dr. Harry Knipp</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/12/69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Baltimore Cemetery</u> |
| 24D. LOCATION
<u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 11 1969</u> | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Weber, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Witzke, 4116 Edmondson Ave., 21229</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5905 | |
|--|--|--|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | SPENCER W. BLOCKMON | | June 9, 1969 M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

2815 Harlem Avenue | | | A. STATE
MARYLAND | | |
| | | | B. COUNTY | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX
Male | | | 6. RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
9-23-1902 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday)
66 |
| Retired | | | Construction Work | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | 11. BIRTHPLACE (State or foreign country) |
| William Blockmon | | | Laura Harlem | | Howard Co., Maryland |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 12. CITIZEN OF WHAT COUNTRY? |
| No. | | | 217-07-9749 | | U.S.A. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| <p>I (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | <p>Respiratory failure</p> <p>Hypertensive cardiovascular disease</p> <p>Renal disease</p> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| (APPROX.) | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from June 4, 1969 to June 9, 1969, that (I) (we) last saw the deceased alive on June 4, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| SBOROTSKY | | | 6/10/69 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| SBOROTSKY | | | 601 N. Howard St. Baltimore, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 6-13-69 | | Highland Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 11 1969 | | David E. Taylor, R.D. | | MORTON & BETT F.H. 1701 Laurens St. | |

22 September

to the same number of the same

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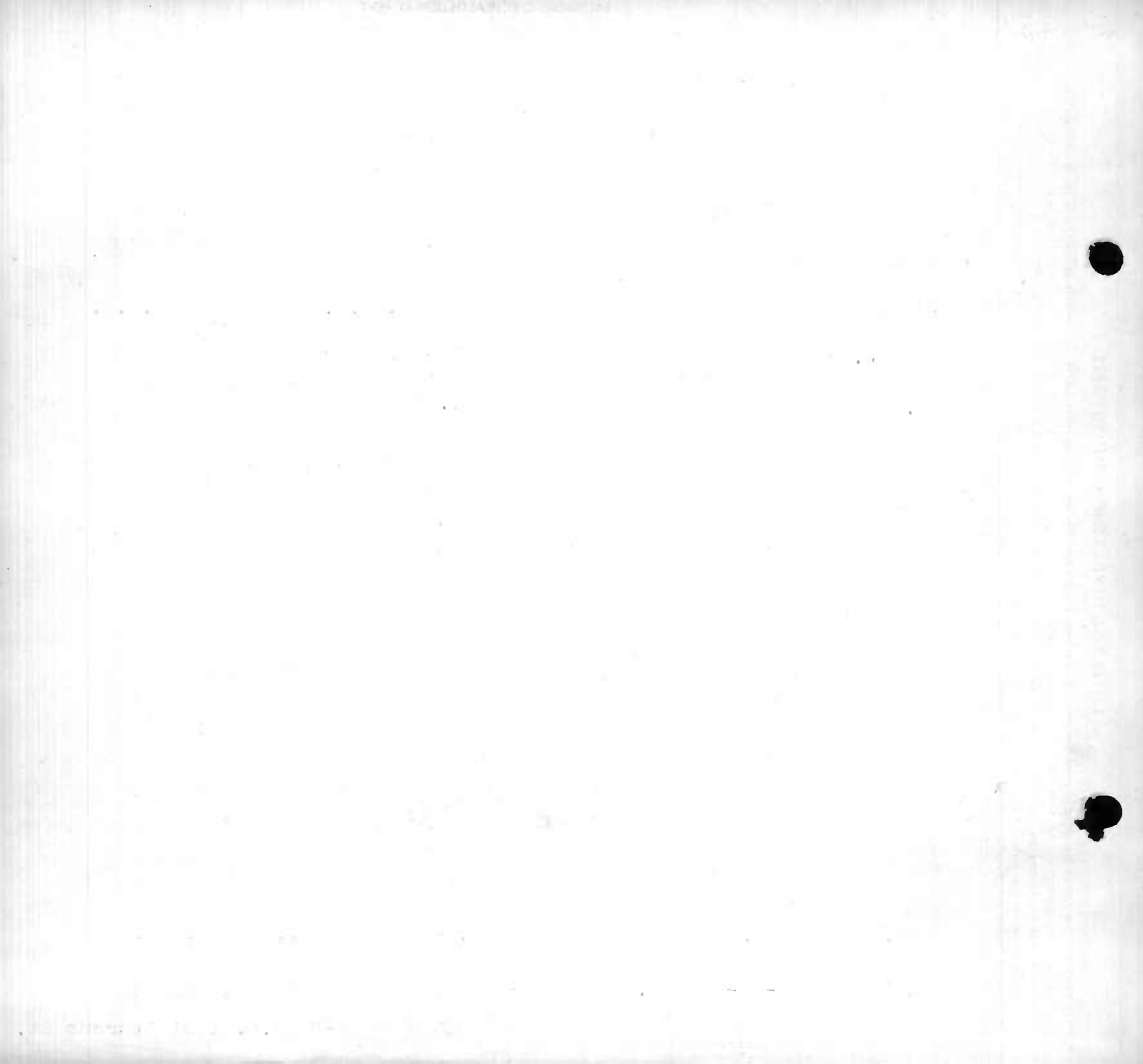
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|--|--|---|---|--|--|---------------------------------|--|---|--|----------------------------------|--|--|
| 69 5906 CERTIFICATE OF DEATH | | | | | REG. NO. 69 5906 | | | | | | | | | |
| BIRTH NO. | | | | | 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| | | | | | GEORGIA COLEMAN | | | | | June 8, 1969 1 A.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | A. STATE | | | | | B. COUNTY | | | | |
| | | | | | MARYLAND | | | | | BALTO. CO. | | | | |
| 7216 Beech Avenue | | | | | C. CITY OR TOWN | | | | | D. INSIDE CITY LIMITS? | | | | |
| | | | | | BALTIMORE | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| E. STREET AND NUMBER | | | | | 7216 Beech Avenue | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | If Under 1 Yr. Months | | If Under 24 Hrs. Days Hours Min. | | |
| Female | | Negro | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8-2-1897 | | 72 | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | | | | |
| RETIRED | | | | | | | | | | Sumpter, S.C. | | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Unk. | | | | | Elizabeth Johns | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | | |
| No. | | | | | | | | | | Mrs. Inez Parker 7216 Beech Avenue | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | |
| | | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1954 to June 8, 1969, that (I) (we) last saw the deceased alive on June 7, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE
DR. RICHARD R. RIGLER | | | | | | | | | | 23B. DATE SIGNED | | | | |
| 23C. PHYSICIAN'S NAME (Print) | | | | | | | | | | 23D. ADDRESS | | | | |
| | | | | | | | | | | 1 W. Overlea Ave., Balto, Md. 21206 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | | | | | | |
| Burial | | 6-11-69 | | Mt. Auburn Cemetery | | Baltimore, Maryland | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | | | | | | |
| JUN 11 1969 | | Robert E. Guba, MD. | | MORTON & DYETT F.H. | | 1701 Laurens St. | | | | | | | | |

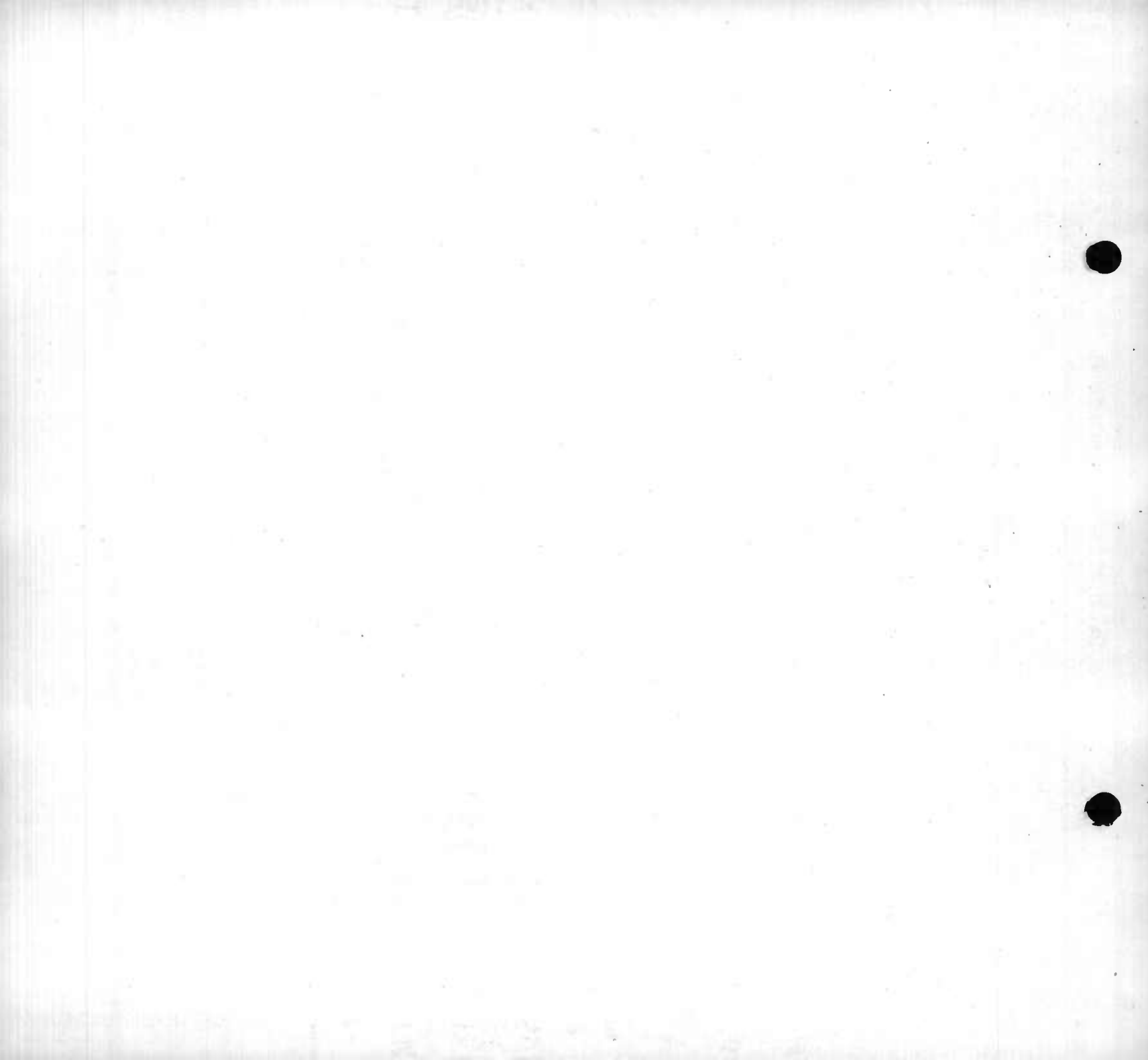


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | 69 5907 | |
|---|---------------------|---|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) MR. JOSEPH Gause JR. | | 2. DATE AND HOUR OF DEATH
6-7-69 10⁴⁰ A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY 20-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
34 BON SECOURS | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
2313 W. LEXINGTON STREET | | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10-8-26 | | 9. AGE (In years last birthday) 43 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOSEPH GAUSE | | | | 14. MOTHER'S MAIDEN NAME
HANNA WASHINGTON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Helena Gause | | ADDRESS
SAME | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
412.21x250.9
Hypertensive encephalopathy with cerebral edema
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) Hypertensive cardiovascular disease
(C) Diabetes Mellitus | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
years | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Diabetes Mellitus | | | | | | | |
| 19A. DATE OF OPERATION
2 - | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-4-69 19 to 6-7-69 19, that (I) (we) last saw the deceased alive on 6-7-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
U. Sangkum | | | | 23B. DATE SIGNED
6-7-69 | | | |
| 23C. PHYSICIAN'S NAME (Type)
U. Sangkum | | | | 23D. ADDRESS
B. S. H. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-12-69 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
258 E. J. B. M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
MORTON & BYETT FUNERAL HOME Balto Md | | | |

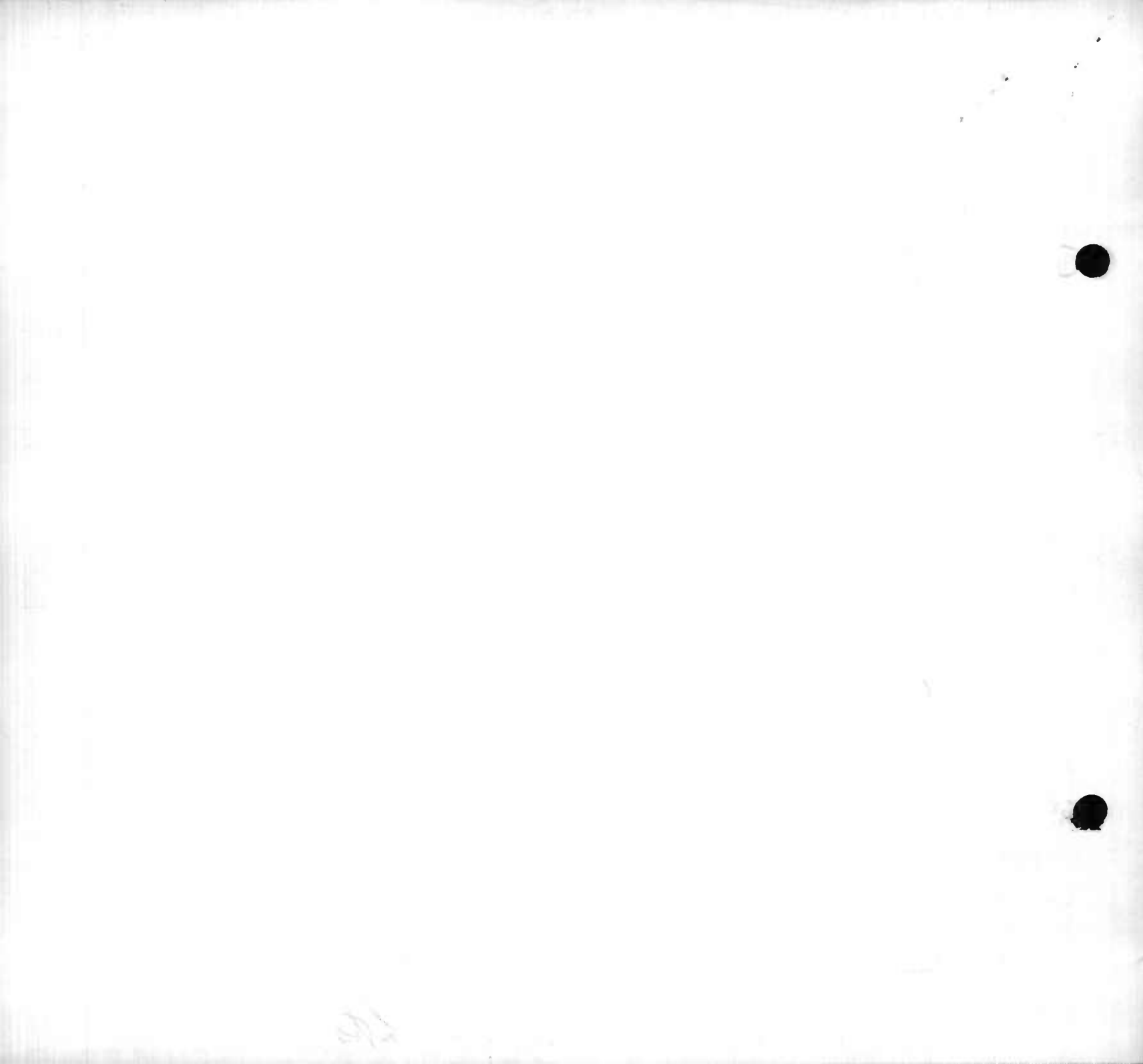
JUN 11 1969



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5908 | |
|--|--|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> H-462 69 5908 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | HOLLARS, HAYES | | 8:10 PM 6/8/69 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | |
| 2 Sinai Hospital, Baltimore Md. 21215 | | | | B. 817 Earlton Rd. Havre de Grace, Md. | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| M | | W | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| Retired | | Cordwood Worker | | 12/16/04 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| Robert Hollars | | ? | | 64 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | Unk. | | Ben. Hollars Earlton Rd. Havre de Grace Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 14201 | | Recurrent Parotid tumor | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 5/28 | | Brain metastasis | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/15 1969 to 6/8 1969 that (I) (we) last saw the deceased alive on 6/8 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| [Signature] | | | | 6/8/69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| [Signature] | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| | | 6/11/69 | | Angel Hill Cym | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 11 1969 | | Robert E. [Signature] | | [Signature] | |
| | | | | ADDRESS | |
| | | | | Havre de Grace, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5909 | |
|--|--|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Pfaff, Walter Melton | | 2. DATE AND HOUR OF DEATH
6/7/69 5:10 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland, B. COUNTY Baltimore City | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNION MEMORIAL HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore City D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
unewriter (keeper) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 1/25/25 9. AGE (In years last birthday) 44 | |
| 13. FATHER'S NAME
Walter M. Pfaff | | 14. MOTHER'S MAIDEN NAME
Amanda Bader | | 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNK | | 16. SOCIAL SECURITY NO.
UNK | | 17. INFORMANT wife Norma J. Pfaff ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
4129 I | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
MI ASCVD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 days yrs. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | D.H. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
II | | N | | | |
| 19A. DATE OF OPERATION 2 No | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/30 1969 to 6/7/1969 that (I) (we) last saw the deceased alive on 6/7 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
BRIAN BLOCK | | 23B. DATE SIGNED
6/7/69 | | 23C. PHYSICIAN'S NAME (Type)
BRIAN BLOCK | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6/11/69 | | 24C. NAME OF CEMETERY OR CREMATORY
WOODLAWN | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
B. B. Brown | |
| 24D. LOCATION
BALTO. MD. | | 24E. ADDRESS
UNION MEMORIAL HOSPITAL | | 24F. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 5910 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. 69 5910 | |
|--|-------------------------|---|------------------------------------|--|--|
| 1. NAME OF DECEASED
(Type or Print) <u>Genevieve Maltrotti</u> | | 2. DATE AND HOUR OF DEATH
<u>6-8-69</u> <u>13:30A</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hosp</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>13-48</u> | | | |
| | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>1332 Weldon Ave</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-04-96</u> | 9. AGE (in years last birthday)
<u>73</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Italy</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Cavanna, Dominick</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Domenica Schenelli</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>-</u> | | 17. INFORMANT
<u>John S Maltrotti San Diego Calif.</u> | | | |
| 18. <u>42701</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Coronary Heart Failure</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Coronary Heart Failure</u> | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>-</u> | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF:
<u>-</u> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<u>6-7-69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>-</u> | | 20A. AUTOPSY? (Yes or No)
<u>Yes No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>-</u> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)
<u>-</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>-</u> | |
| 22. I certify that (H) (this hospital) attended the deceased from <u>5-31</u> 19 <u>69</u> to <u>6-8</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6-7</u> 19 <u>69</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Steph J. [Signature]</u> | | 23B. DATE SIGNED
<u>6-8-69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>-</u> | |
| 23D. ADDRESS
<u>Union Memorial Hosp</u> | | 23E. DEGREE
<u>-</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Buried</u> | | 24B. DATE
<u>6-11-69</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Bethel National Cem</u> | |
| 24D. LOCATION
<u>Bethel, Md.</u> | | 24E. STATE
<u>Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 11 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. [Signature]</u> | | 25C. FUNERAL DIRECTOR
<u>Berger Funeral Home</u> | |
| 25D. ADDRESS
<u>Bethel, Md.</u> | | 25E. STATE
<u>Md.</u> | | | |



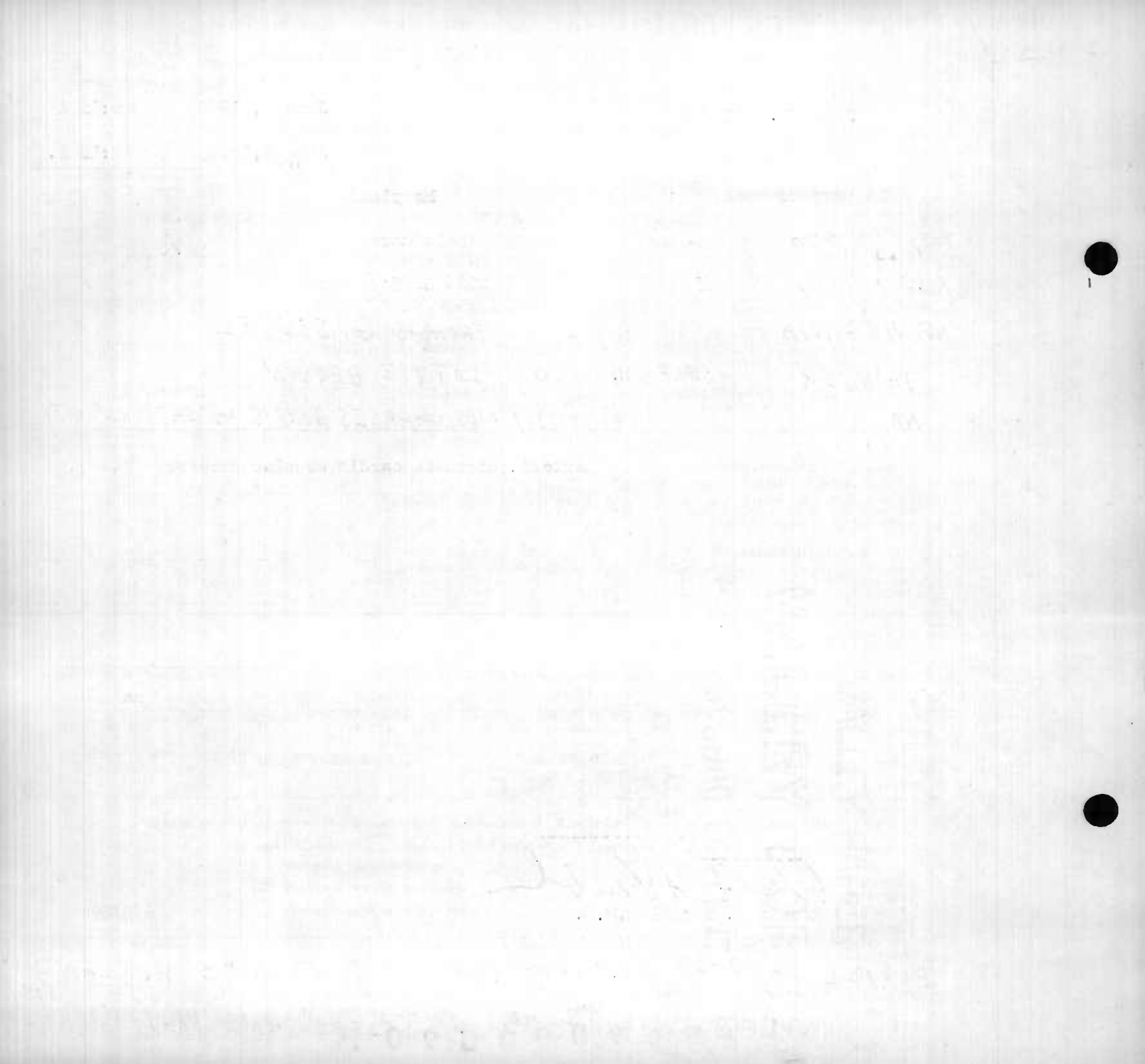
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5911

BIRTH NO.

| | | | |
|---|-------------------------|--|--|
| 1. NAME OF DECEASED
(Type or Print)
JOHN D. SINSEL | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 8, 1969
Hour 9:15 A. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
2926 Harford Road | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 8, 1969
Hour 9:15 A. M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 9-06 | | | |
| 6. SEX
Male | 7. RACE
White | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
MAY 7-1904 | | 10. AGE (In years lost birthday) 65
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
W. VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PAINTER | | 14B. KIND OF BUSINESS OR INDUSTRY
SELF EMPLOYED | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 17. SOCIAL SECURITY NO.
577-18-3367 | |
| 13. FATHER'S NAME
THOMAS G. SINSEL | | 15. MOTHER'S MAIDEN NAME
LOTTIE BROWN | |
| 18. INFORMANT
MRS. CHARLES MORRIS | | ADDRESS
45 SATURN CT. | |
| 19. 412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED
6/9/69 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-10-69 | |
| 24C. NAME of CEMETERY or CREMATORY
NEW CATHEDRAL | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | 25B. NAME OF REGISTRAR
James E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
WALTERS FUNERAL HOME | | ADDRESS
PRATT+STRICKER STS. | |



FUNERAL DIRECTOR: IMPORTANT

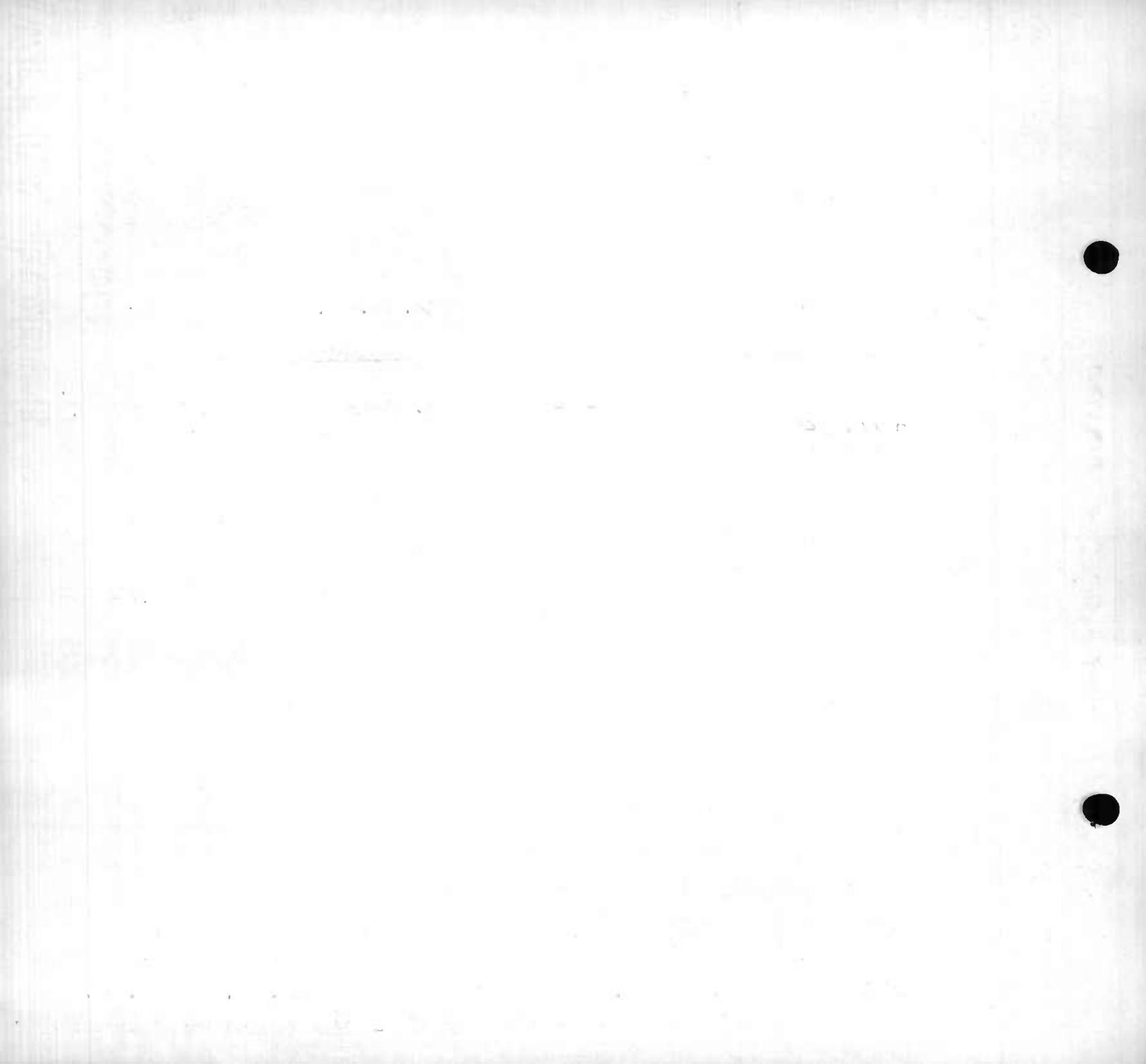
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|--|
| BIRTH NO. <u>69 5912</u> | | | | | REG. NO. <u>69 5912</u> | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>B/B Russell</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>6/9/69</u> <u>11:10 A.M.</u> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>The Johns Hopkins Hospital</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundle</u>
C. CITY OR TOWN <u>Annapolis</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>313 Gibson Road</u> | | | | |
| 5. SEX
<u>Male</u> | | 6. RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>6/7/69</u> | | 9. AGE (in years last birthday)
<u>2</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>—</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>David Russell</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Deborah Mills</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>DAVID RUSSELL #4</u> | | | |
| 18. <u>776.91</u> CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>—</u> | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>—</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>—</u> | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)
<u>—</u> | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>—</u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> 19 <u>69</u> to <u>6/9</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/9</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>D.L. Headings M.D.</u> | | | | | | | | 23B. DATE SIGNED
<u>6/9/69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>D.L. HEADINGS, M.D.</u> | | | | 23D. ADDRESS
<u>JOHNS HOPKINS HOSPITAL</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>6-11-69</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>HILLCREST</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Annapolis A.A. MD.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 11 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>John M. Taylor, M.D.</u> | | 25D. ADDRESS
<u>52-10</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

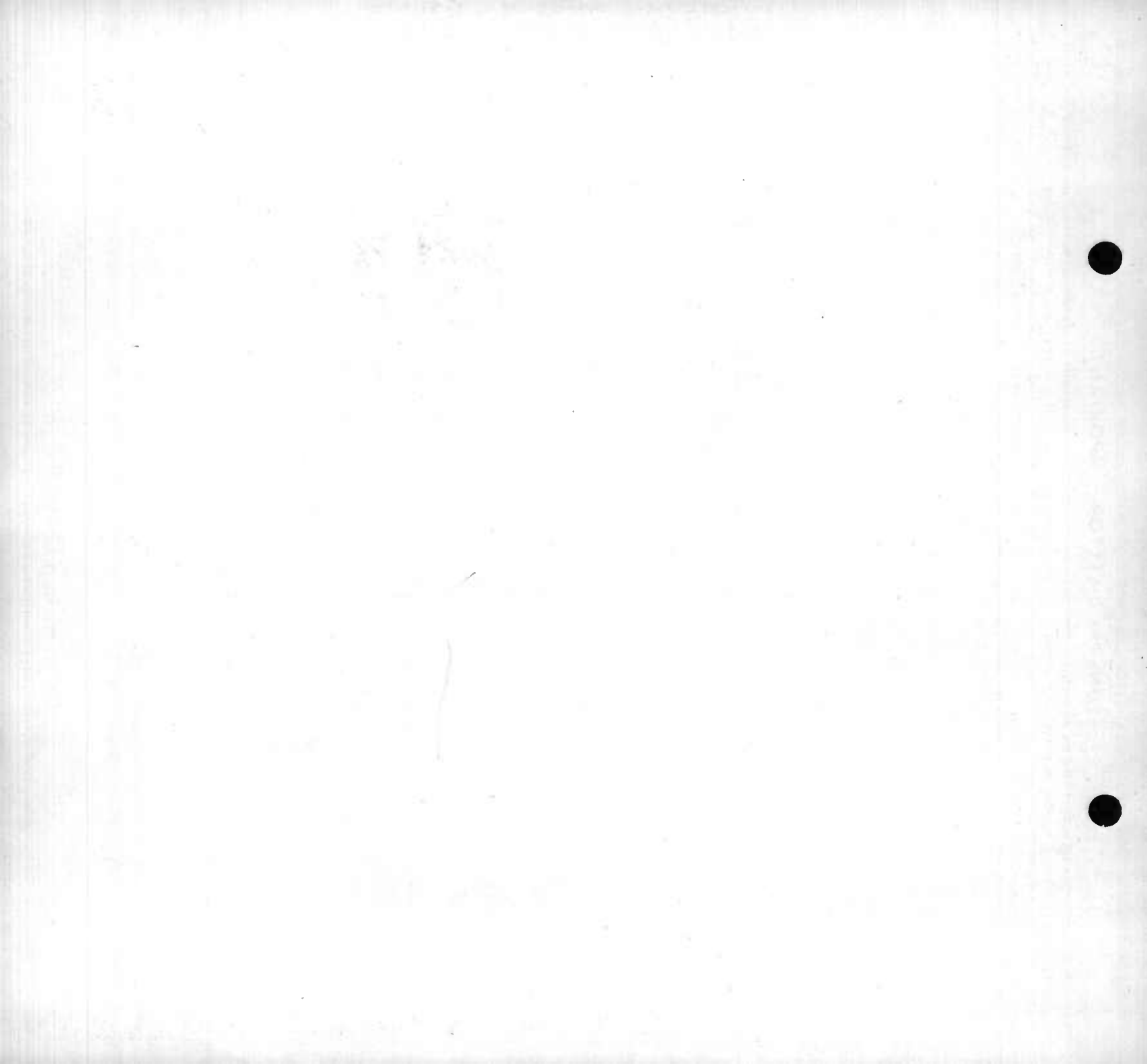
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5914</u> |
|---|-------------------------|---|-----------------------------------|---|
| 69 5914 | | CERTIFICATE OF DEATH | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Cecelia Marie Dannenmann</u> | | 2. DATE AND HOUR OF DEATH
<u>June 9 1969 4:35 A.M.</u> |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>2-01</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>33 The Johns Hopkins Hospital</u> | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER
<u>Gough 1933 Gulf Street</u> | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7/8/17</u> | 9. AGE (In years last birthday) <u>51</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Can Packer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Metal Container</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> |
| 13. FATHER'S NAME
<u>Harry Carman</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>Katherine Keelie Neely</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>-</u> | | |
| 16. SOCIAL SECURITY NO.
<u>Not Known</u> | | 17. INFORMANT ADDRESS
<u>Mr. John N. Dannenmann, 1933 Gough St.</u> | | |
| 18. <u>573.9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>MALNUTRITION</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) <u>HEPATIC FAILURE</u> | | |
| 19. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (1) (this hospital) attended the deceased from <u>May 27 1969</u> to <u>June 9 1969</u> . that (1) (we) last saw the deceased alive on <u>June 9 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Matthew Pollock MD</u> | | 23B. DATE SIGNED
<u>June 9 1969</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>MATTHEW POLLOCK MD</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/12/69</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Holy Rosary</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 11 1969</u> | | 25B. NAME OF REGISTRAR
<u>John E. Fisher, R.D.</u> | | 25C. FUNERAL DIRECTOR
<u>M. J. Sadowski & SONS, 1808 Eastern Ave</u> |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5915 |
|---|---------------------|---|--------------------------------------|---|
| BIRTH NO. 69 5915 | | CERTIFICATE OF DEATH
(CLUDWIKI) | | |
| 1. NAME OF DECEASED
(Type or Print) TRUSZKOWSKI MRS LOUISE | | 2. DATE AND HOUR OF DEATH
6-9-69 5-22 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
CHURCH HOME HOSPITAL | | A. STATE MD
B. COUNTY 2-03 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 35 | | E. STREET AND NUMBER
512 S. WASHINGTON ST | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
NOV. 8-76 | 9. AGE (In years last birthday)
92 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
POLAND |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | 13. FATHER'S NAME
LEOPOLE BLUSIEWICZ | | |
| 14. MOTHER'S MAIDEN NAME
PAULINE FRAZKIEWICZ | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO.
213522656 | | 17. INFORMANT
CHART | | |
| 18. 431.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| (A) IMMEDIATE CAUSE
Cerebral hemorrhage | | Five days | | |
| (B) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF: | | Five days | | |
| (C) Art. sclerosis | | years | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (H) (this hospital) attended the deceased from 5-22-1969 to 6-9-1969 , that (H) (we) last saw the deceased alive on 6-9-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Joseph Nidiry M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
6-9-69 |
| 23C. PHYSICIAN'S NAME (Type)
JOSEPH NIDIRY | | 23D. ADDRESS
CHURCH HOME HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-13-69 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cem. |
| 24D. LOCATION
Balto. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | |
| 25B. NAME OF REGISTRAR
John E. Zabel, Md. | | 25C. FUNERAL DIRECTOR
W. Piatkowski | | |
| 25D. ADDRESS
2007 Eastern Ave | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5916 | |
|--|---|---|--|--|---|
| BIRTH NO. W-622 69 5916 | | | | | |
| 1. NAME OF DECEASED (Type or Print) WRZESINSKI, DORIS
Wrzesinski, Doris | | | 2. DATE AND HOUR OF DEATH 6/7/69 1015 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN ESSE A D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 931 HOMBERG AVENUE 21221 | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-21-26 | 9. AGE (In years last birthday) 42 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY WARDS | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JAMES E. GRINDLE | | | 14. MOTHER'S MAIDEN NAME P | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) VNK | | 16. SOCIAL SECURITY NO. 208 16 4078 | 17. INFORMANT BCH RECORDS-4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | |
| 18. 430.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Subarachnoid Hemorrhage
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
hypertension
anti coagulants | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days
several years
months | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Antenna | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) NO | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notably medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/2/69 to 6/7/69 19 69 that (I) (we) last saw the deceased alive on 6/7/69 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William W. Brockman | | | 23B. DATE SIGNED 6/7/69 | | |
| 23C. PHYSICIAN'S NAME (Type) William W. Brockman | | | 23D. ADDRESS BALTIMORE, MD. 21224
Balt. City Hosp 4940 EASTERN AVE. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 6/11/69 | 24C. NAME OF CEMETERY or CREMATORY BALTO. NATL | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 11 1969 | | 25B. NAME OF REGISTRAR Wm E. Fisher, M.D. | 25C. FUNERAL DIRECTOR CONNELLY SONS ADDRESS 300 MACE | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

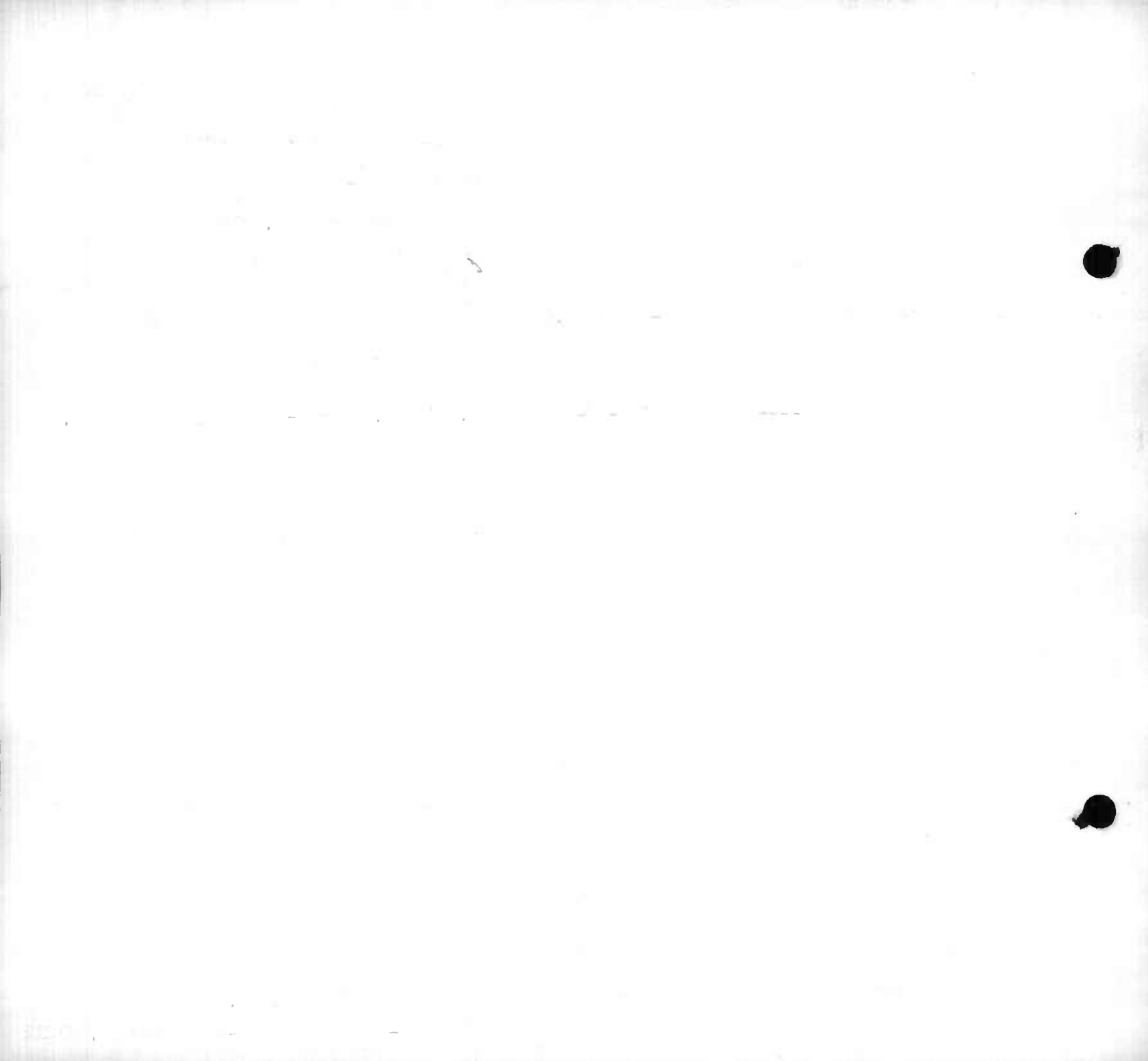
| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>69 5917</u> | |
|--|----------------------|---|--|--|---|
| BIRTH NO. <u>R-200 69 5917</u> | | 1. NAME OF DECEASED
(Type or Print) <u>ERNEST E. ROACH</u> | | 2. DATE AND HOUR OF DEATH
<u>6-6-69</u> <u>9:20 P</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>THE JOHNS HOPKINS HOSPITAL</u>
<u>33</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO. CO.</u>
C. CITY OR TOWN <u>MIDDLE RIVER</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <u>2 PLASTIC COURT</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-3-21</u> | 9. AGE (In years last birthday) <u>47</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Mechanist Helper</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Steel Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Cumberland, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | 13. FATHER'S NAME
<u>ENOCH ROACH</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>EULA PEER</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>yes</u> <u>War II Army</u> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
<u>Mrs. Dorothy Roach, Baltimore, Md. Wife</u> | | |
| 18. <u>432.9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)
<u>PULMONARY EMBOLUS</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>PARAPLEGIA</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>ANT SPINAL A. THROMBOSIS</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 hrs</u>
<u>15 days</u>
<u>15 days</u> | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<u>5/23/69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Paraplegia</u> | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>5/21/69</u> 19 <u>69</u> to <u>6/6</u> 19 <u>69</u> that (1) (we) last saw the deceased alive on <u>6/6</u> 19 <u>69</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Edward R. Laws, MD</u> | | | 23B. DATE SIGNED
<u>6/6/69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>EDWARD R. LAWS, JR</u> MD DEGREE |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 24B. DATE
<u>June 10, 1969</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Sunset Memorial Park</u> |
| 24D. LOCATION (City, town, or county) (State)
<u>Cumberland, Allegany, Md.</u> | | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 11 1969</u> | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, MD</u> | | | 25C. FUNERAL DIRECTOR
<u>James R. Scarpelli, Cumberland, Md.</u> | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 5918 | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 69 5918 | |
|---|------------------|---|-----------------------------------|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Winfield S. Guerke</u> | | 2. DATE AND HOUR OF DEATH
<u>6/6/69</u> <u>4:25</u> P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>University Hospital</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <u>Baltimore</u>
B. COUNTY <u>Harford</u>
C. CITY OR TOWN <u>Balto. Md</u>
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>256 Rodgers Forge Rd, 21212</u> | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7/3/99</u> | 9. AGE (In years last birthday) <u>69</u> | 10. Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Clerk-B & O RR.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | 13. FATHER'S NAME
<u>Charles F. Guerke</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Long</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>705-05-0198A</u> | | 17. INFORMANT
<u>Mrs. Ruby W. Guerke-256 Rodgers Forge Rd.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Peritonitis</u> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Perforated Gastric</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6/5/69</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Cerebral Atrophy</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>Aug 68</u> | | | |
| (C) _____ | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>Cerebral Atrophy</u> | | | | | |
| 19A. DATE OF OPERATION
<u>6/5/69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Perforated Gastric Ulcer</u> | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/5/69</u> 19 <u>69</u> to <u>6/6</u> 19 <u>69</u> that (H) (we) last saw the deceased alive on <u>6/6</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>J. J. Oldroyd M.D.</u> | | 23B. DATE SIGNED
<u>6/6/69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>J. J. Oldroyd M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/9/69</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Baltimore Cemetery</u> | |
| 24D. LOCATION
<u>Baltimore, Md.</u> | | 24E. NAME OF REGISTRAR
<u>Edgar E. Barber, Jr.</u> | | 24F. FUNERAL DIRECTOR
<u>Mitchell-Wiedefeld Home-6500 York Rd. 21212</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 11 1969</u> | | 25B. NAME OF REGISTRAR
<u>Edgar E. Barber, Jr.</u> | | 25C. FUNERAL DIRECTOR
<u>Mitchell-Wiedefeld Home-6500 York Rd. 21212</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 5919 | | BALTIMORE CITY HEALTH DEPARTMENT | | 69 5919 | |
|---|------------------|---|--|---|---------------------------------------|
| CERTIFICATE OF DEATH | | | | REG. NO. | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Mc Coy, Leroy | | June 4, 1969 9:35 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
The Johns Hopkins Hospital
33 | | | | A. STATE
Maryland
10-02 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
BALTO, Md. | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
BALTO, Md. 1225 Madison St. | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6-11-11 | 9. AGE (In years last birthday)
57 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
North Carolina | |
| 13. FATHER'S NAME
Matthew McCoy | | 14. MOTHER'S MAIDEN NAME
Kellye Smith | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
219-07-8429 | | 17. INFORMANT
Mrs Myrtle McCoy 1525 Barclay St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Cardio Respiratory Arrest
(B) IMPROBABLE CAUSE OF DEATH
DUE TO, OR AS A CONSEQUENCE OF:
Inoperable Ca of Lung
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/4 1969 to 6/4 1969 that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Philip R. Reid | | | | 23B. DATE SIGNED
6/5/69 | |
| 23C. PHYSICIAN'S NAME (Type)
PHILIP R. REID | | | | 23D. ADDRESS
Johns Hopkins | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/10/69 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
A A County Md | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | | |
| 25B. NAME OF REGISTRAR
E. J. B. M.D. | | 25C. FUNERAL DIRECTOR
A J. H. H. | | | |
| 25D. ADDRESS
1206 W North Ave | | | | | |



69 5920

BALTIMORE CITY HEALTH DEPARTMENT

69 5920

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

FRANCIS DAY

2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

June 7, 1969

11:25 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1628 E. Pratt Street

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

June 7, 1969

11:25 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

5.01

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1/9/29

10. AGE (In years last birthday)

40

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

131 N. Aisquith Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

Ely Day

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Matilda

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mrs Inell Day 919 Duncan St

19. 746.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Intra-Atrial Septal Defect

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/8/69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/12/69

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 11 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

1/1/59

Harryland

Unemployed

U S A

Ely Day

Matilda

Mrs Inell Day Simpson

Adolphus Halstead 1500 W. 1st St.
Baltimore, Md.
Cemetery

6/12/59

Burial

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MEDICAL CERTIFICATION

| | | | | | |
|---|--|---|--|--|--|
| 18. <u>4/10/69</u> I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving
rise to the above cause [A] stating the
UNDERLYING CONDITION last. | | CAUSE OF DEATH
<u>Acute Myocardial Infarction</u>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

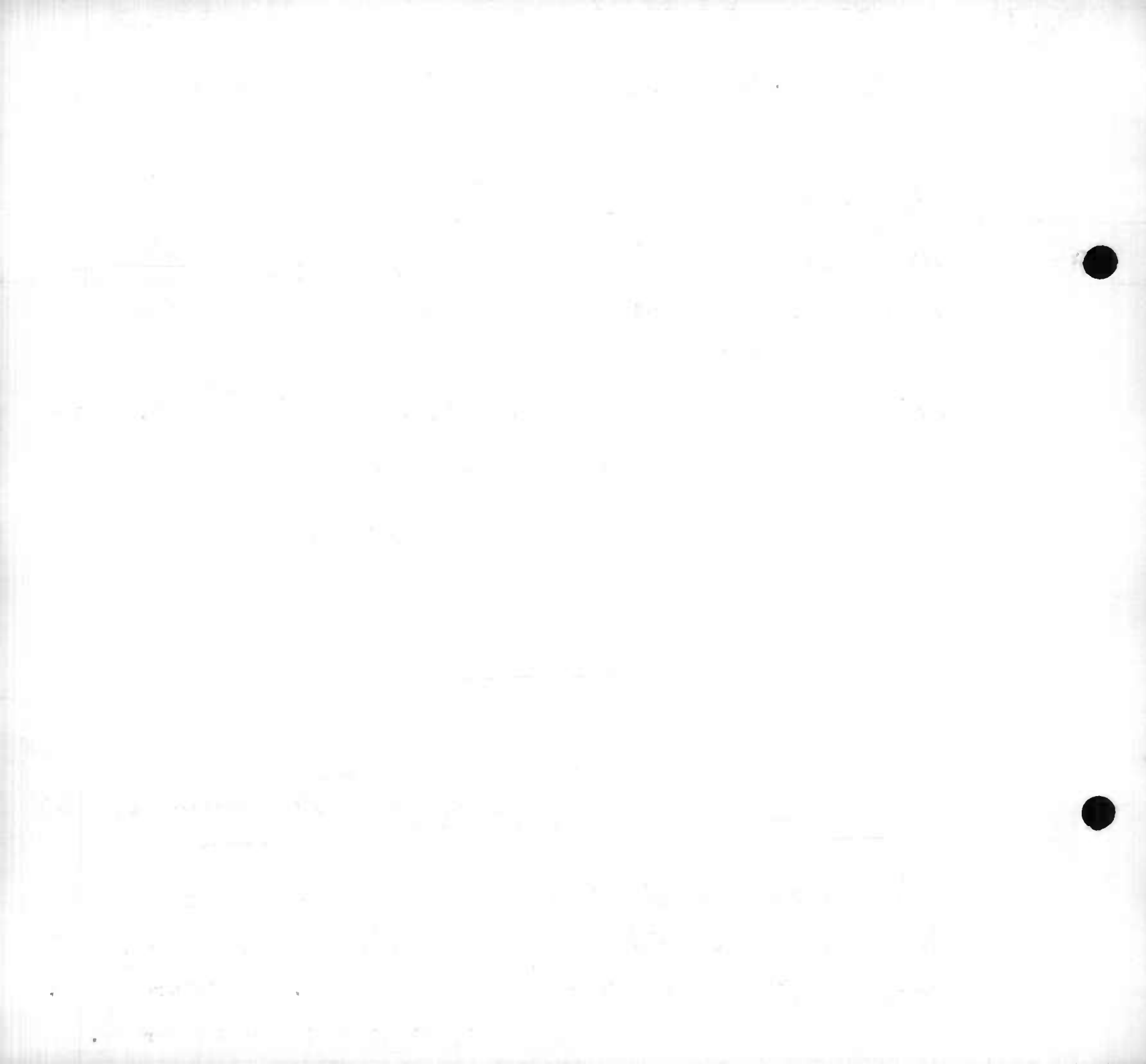
<u>Arteriosclerotic Heart Disease</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>~ 12 hours</u>

<u>?</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED _____ | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | 21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME
OF INJURY
(APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At _____ Not While
Work _____ At Work _____ | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 8, 1969</u> to <u>June 8, 1969</u>
that (I) (we) last saw the deceased alive on <u>June 8, 1969</u> and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>William L. Boddie M.D.</u> | | | | 23B. DATE SIGNED
<u>6-8-69</u> | |
| 23C. PHYSICIAN'S
NAME (Type)
<u>William L. Boddie M.D.</u> | | | | 23D. ADDRESS
<u>Maryland General Hospital</u> | |
| 24A. BURIAL-CREATION,
REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/11/69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>New Cathedral Cemetery</u> | |
| 24D. LOCATION
<u>Fred Rd.</u> | | <u>Baltimore</u> | | <u>Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 11 1969</u> | | 25B. NAME OF REGISTRAR
<u>James E. Jaber, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Mitchell Wiedefeld Home</u> | |
| | | | | ADDRESS
<u>6500 York Rd.</u> | |

| | | | | | |
|---|---------------------|---|---|--|---|
| BIRTH NO.
69 5921 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. 69 5921 | |
| 1. NAME OF DECEASED
(Type or Print)
<u>Arnold G. Lohrfink</u> | | | 2. DATE AND HOUR OF DEATH
<u>June 8, 1969 1 8:22 P. M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>Maryland General Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>12-02</u> | | |
| | | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<u>3003 N. Charles</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/28/43</u> | 9. AGE (in years last birthday)
<u>76</u> | 10. If Under 1 Tr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Clerk</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Electric -</u> | | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | |
| 13. FATHER'S NAME
<u>John Lohrfink</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Carman</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>212-03-8571</u> | | |
| | | | 17. INFORMANT
<u>Ethel H. Lohrfink</u> ADDRESS
<u>3003 N. Charles</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

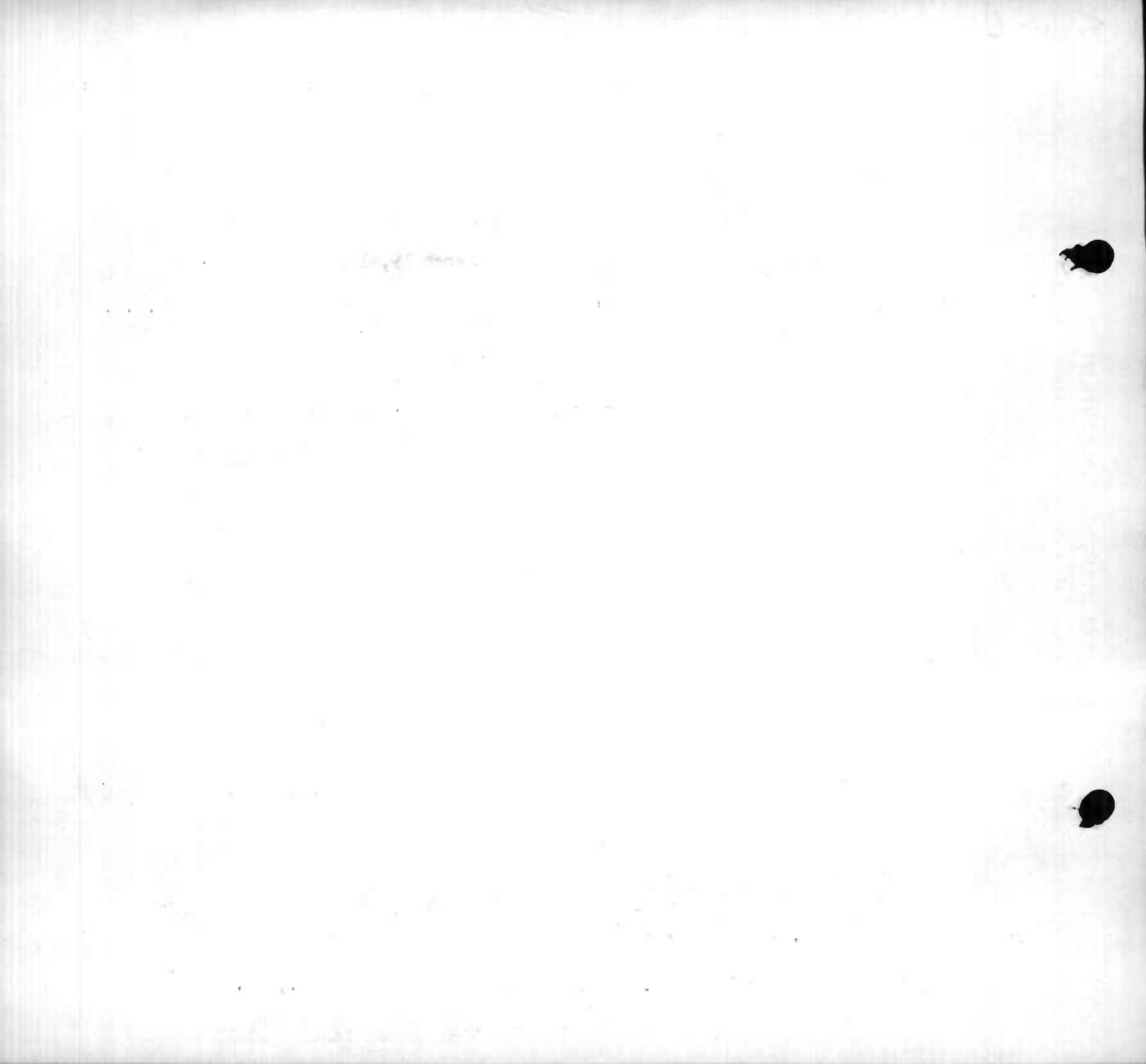
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5922</u> |
|---|--|---|--|---|
| 69 5922 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| JOSEPH MARTIN KRAMER | | JUNE 6, 1969 8:30 a.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3001 The Alameda
Baltimore, Maryland 21218 | | A. STATE
Maryland | | |
| | | B. COUNTY
Baltimore | | |
| 5. SEX
male | | 6. RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Butcher | | 10B. KIND OF BUSINESS OR INDUSTRY
Carmen D'Anna | | 8. DATE OF BIRTH
March 19, 1885 84 yrs. |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Ida ? | | 9. AGE (In years last birthday)
84 yrs. |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
212-01-8842 A | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 17. INFORMANT
Anna M. Kramer, wife, above | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
<i>Arteriosclerotic Cardio Vascular Disease</i>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

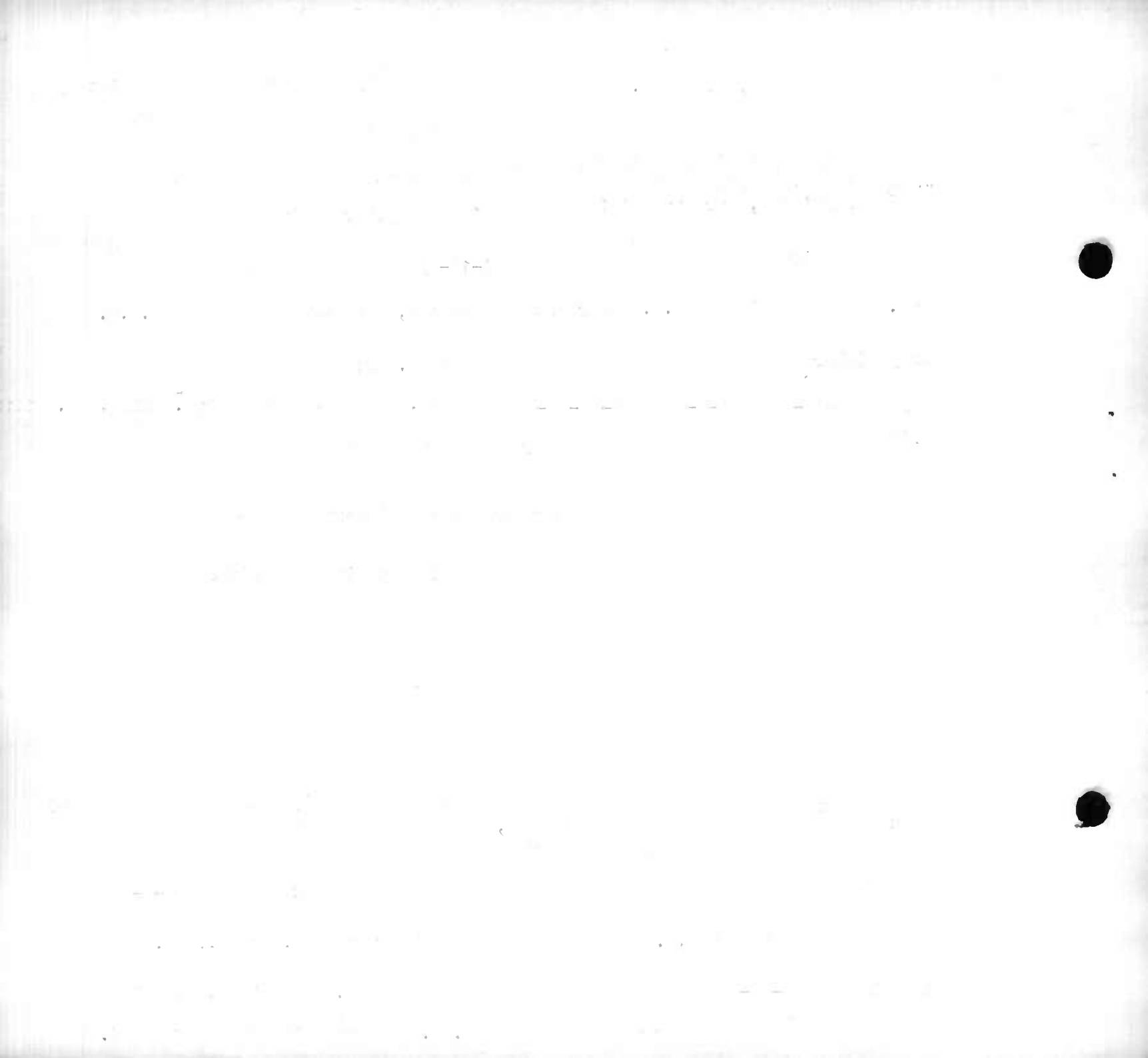
(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>6/6/69</u> 19 <u>69</u> , that (I) (was) lost saw the deceased alive on <u>5/27/69</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<i>Thomas L. Worsley</i> | | 23B. DATE SIGNED
6/9/69 | | 23C. PHYSICIAN'S NAME (Type)
Dr. Thomas Worsley |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/9/69 | | 24C. NAME OF CEMETERY or CREMATORY
St. Stanislaus Cemetery |
| 24D. LOCATION
Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | |
| 25B. NAME OF REGISTRAR
<i>Paul E. Taylor, R.D.</i> | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home
3331 Brehms Lane 21213 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5923</u> |
|---|--|--|--|---|
| BIRTH NO. <u>69 5923</u> | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print)
FISHER, MILTON C. | | 2. DATE AND HOUR OF DEATH
June 8, 1969 2:10 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Florida B. COUNTY Pinellas | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
23 Veterans Administration Hospital
3900 Loch Raven Blvd
Baltimore, Maryland 21218 | | C. CITY OR TOWN
St Peterburg | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX
Male | | 6. RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Govt. Employee Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
U.S. Government | | 8. DATE OF BIRTH
4-14-93 |
| 13. FATHER'S NAME
Harry Fisher | | 14. MOTHER'S MAIDEN NAME
Nancy L. Troy | | 9. AGE (In years last birthday)
76 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 5-19-17 to 2-4-19 | | 16. SOCIAL SECURITY NO.
264-78-66-40 | | 11. BIRTHPLACE (State or foreign country)
Caronaa, New York |
| | | 17. INFORMANT
Records | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| | | 17. ADDRESS
VA Hosp. 3900 Loch Raven Blvd. Balto. Md. 21218 | | |
| 18. CAUSE OF DEATH
410.9 I Myocardial Infarction
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Artery Disease
(B) DUE TO, OR AS A CONSEQUENCE OF: S/P Release of Intestinal Adhesions
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (H) (this hospital) attended the deceased from June 4 19 69 to June 8 19 69 that (X) (we) last saw the deceased alive on June 8 , 19 69 and that (H) (our) opinion of death occurred on the date and hour and from the causes stated above. (X) (We) (did) (H) view the body after death. | | | | |
| 23A. SIGNATURE
S. Nasrallah M.D. | | 23B. DATE SIGNED
6-8-69 | | 23C. PHYSICIAN'S NAME (Type)
S Nasrallah M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
6-10-69 | | 24C. NAME OF CEMETERY OR CREMATORY
St. Petersburg, Florida |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
W. E. Johnson |
| | | | | ADDRESS
8521 Loch Raven Blvd. |



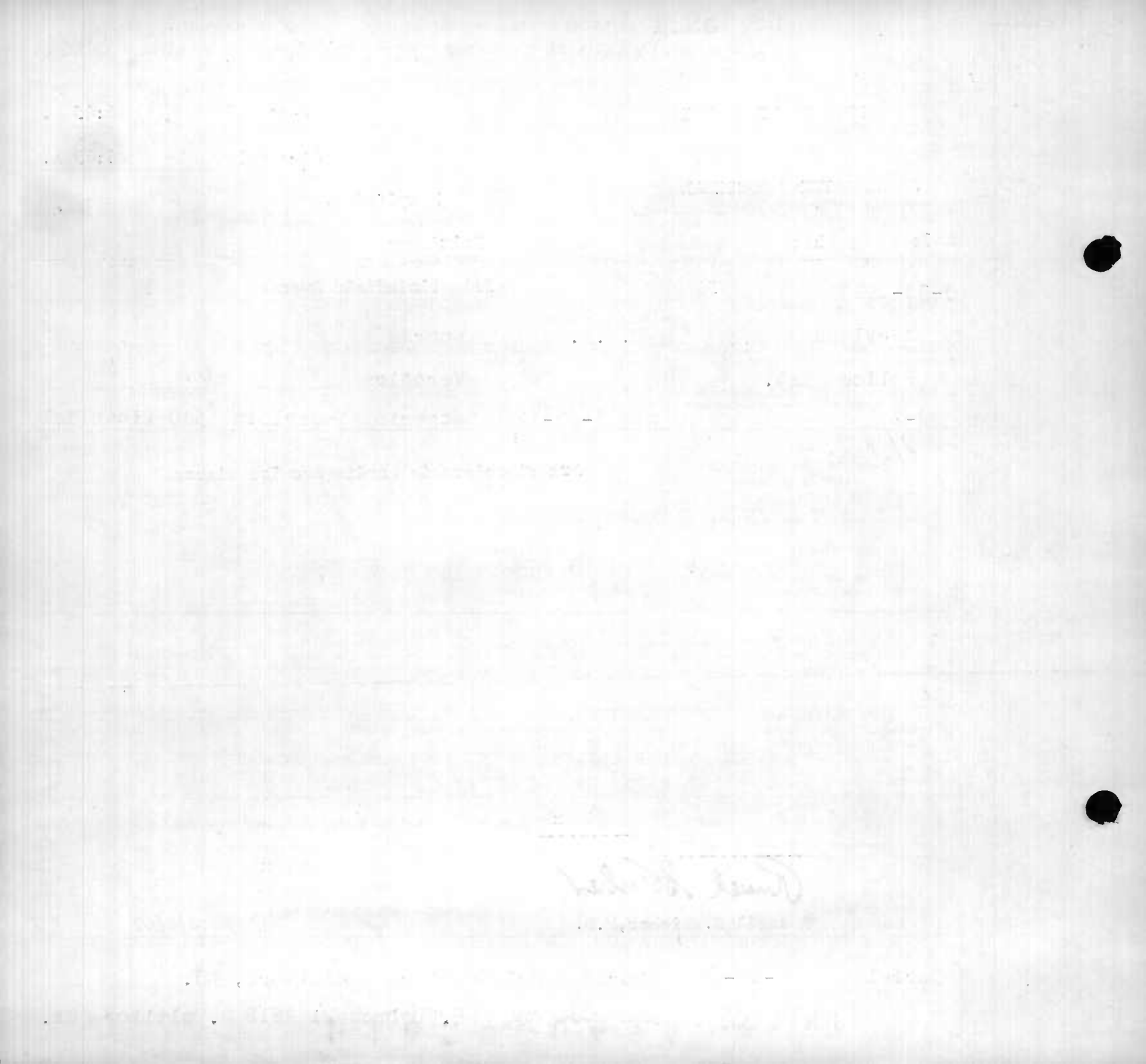
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5924

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) EDWARD MINDERLEIN | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 8, 1969 Hour 6:45 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
JOHNS HOPKINS HOSPITAL | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 8, 1969 6:45 A.M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
3-31-1915 | | 10. AGE (in years last birthday) 54 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Police Ret. | | 15. MOTHER'S MAIDEN NAME
Veronica | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
WW-2 | | 17. SOCIAL SECURITY NO.
213-03-1768 | |
| 18. INFORMANT
Catherin Minderlein | | ADDRESS
5510 Plainfield | |
| 19. CAUSE OF DEATH
412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF:
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION
0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) (Minute) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Russell S. Fisher M.D.
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.
DATE SIGNED 6/8/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-12-69 | |
| 24C. NAME OF CEMETERY or CREMATORY
Sacred Heart Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | 25B. NAME OF REGISTRAR
James E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
B. Dabrowski | | ADDRESS
2818 E. Baltimore St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

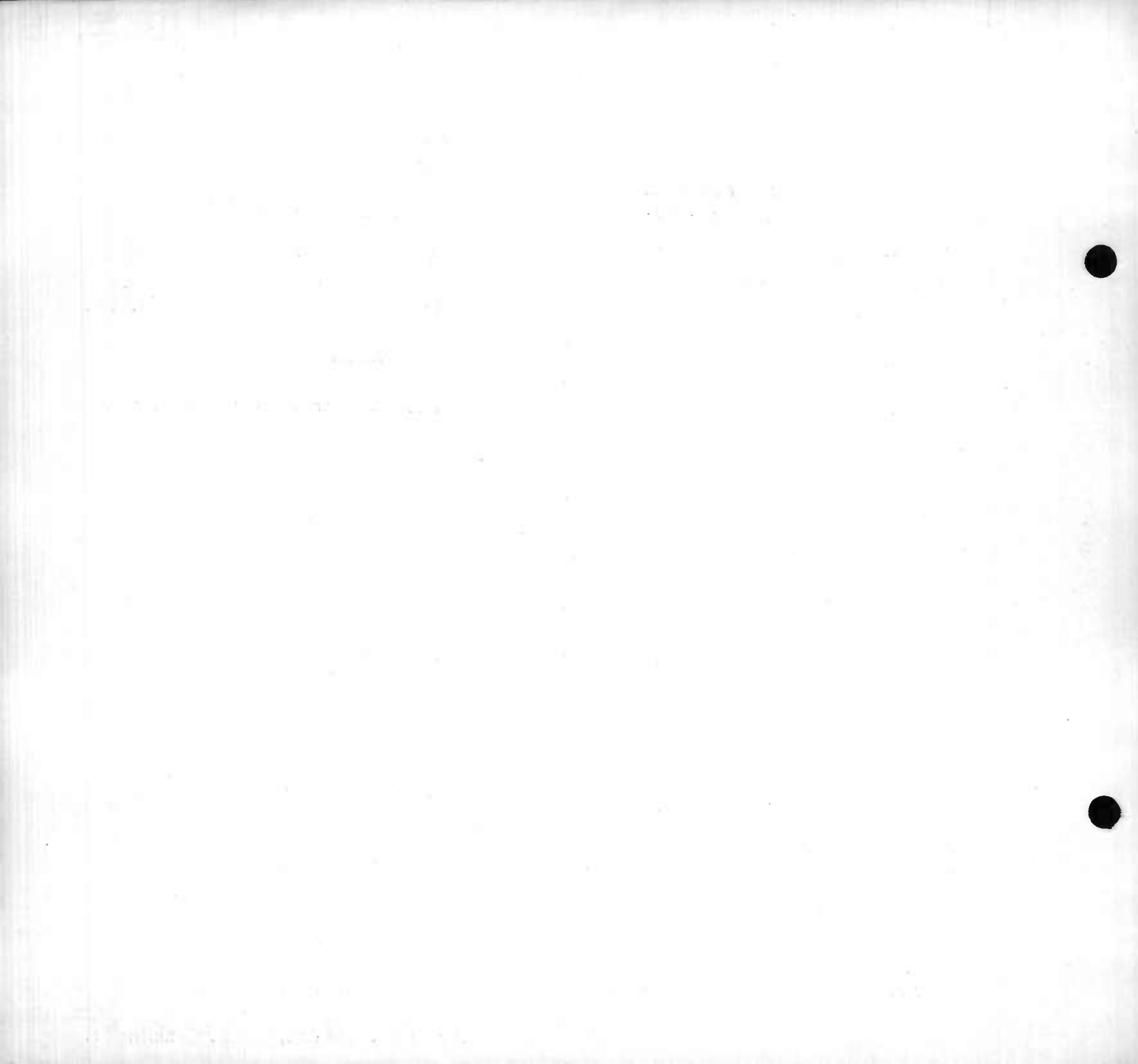
69 5925

| | | | | | |
|---|--------------|---|--|---|---------------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Maria Rosa Glorioso | | June 7, 1969 8:15 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 Melchor Nursing Home
2327 N. Charles Street | | | | A. STATE
Maryland | |
| | | | | B. COUNTY
Baltimore | |
| | | | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
2327 N. Charles Street | |
| 5. SEX
Fem. | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4/21/1882 | 9. AGE (In years lost birthday)
87 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Italy | |
| 13. FATHER'S NAME
Joseph DeLuca | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | | | 14. MOTHER'S MAIDEN NAME
Sartalamacchia | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
Mr. Joseph Glorioso 6720 Bessemer Avenue | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Cerebral Arteriosclerosis
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

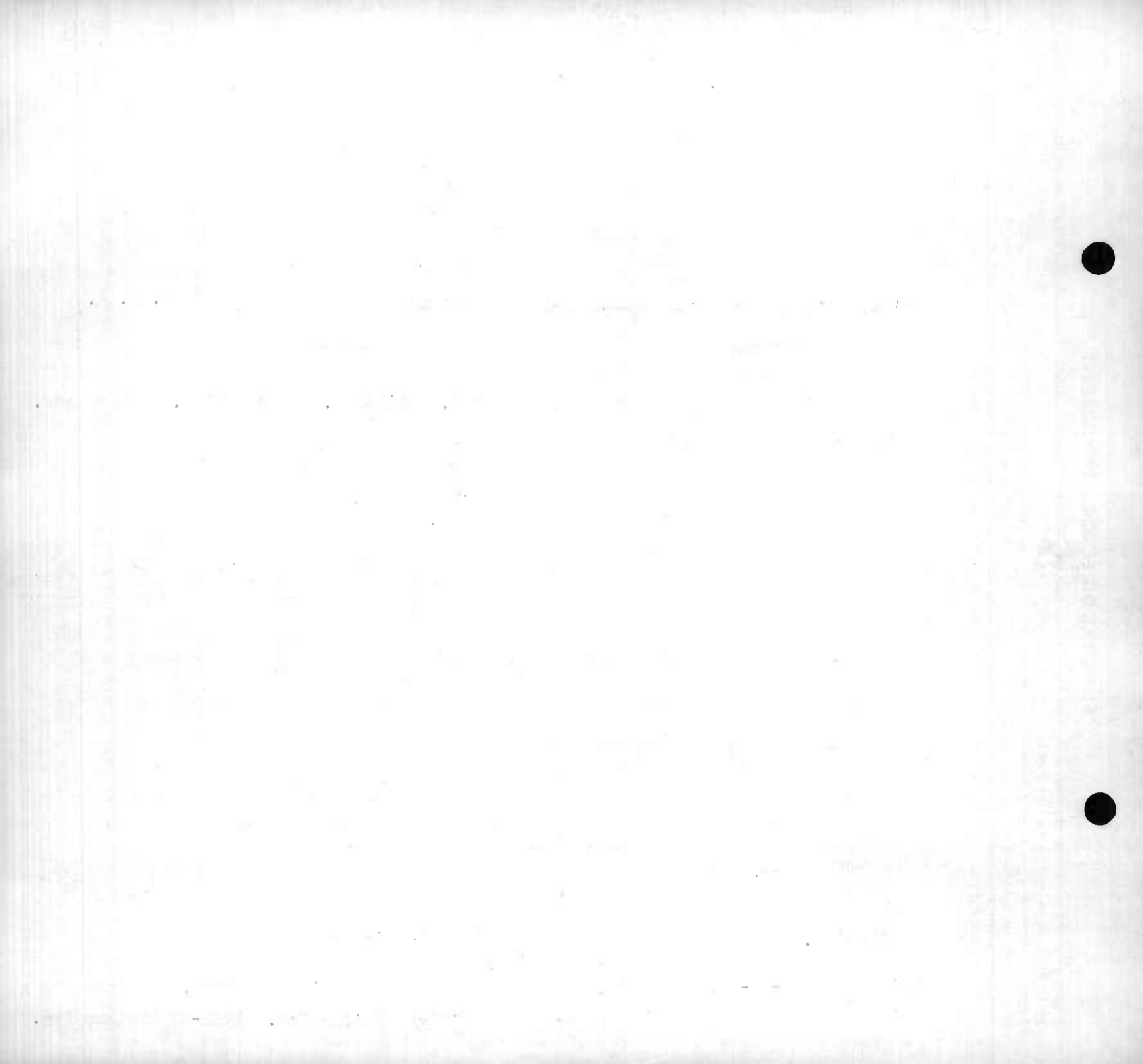
Generalized Arteriosclerosis
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Several years
Several years | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 19 68 to June 19 69, that (I) (we) last saw the deceased alive on June 6 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Loy M. Zimmerman M.D. | | | | 23B. DATE SIGNED
6/7/69 | |
| 23C. PHYSICIAN'S NAME (Type)
Loy M. Zimmerman M.D. | | | | 23D. ADDRESS
3202 Harford Road | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/9/69 | | 24C. NAME of CEMETERY or CREMATORY
Most Holy Redeemer | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Robert E. Taylor, R.D. | | 25C. FUNERAL DIRECTOR
Joseph N. Zanningo | |
| | | | | ADDRESS
263 S. Conkling St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

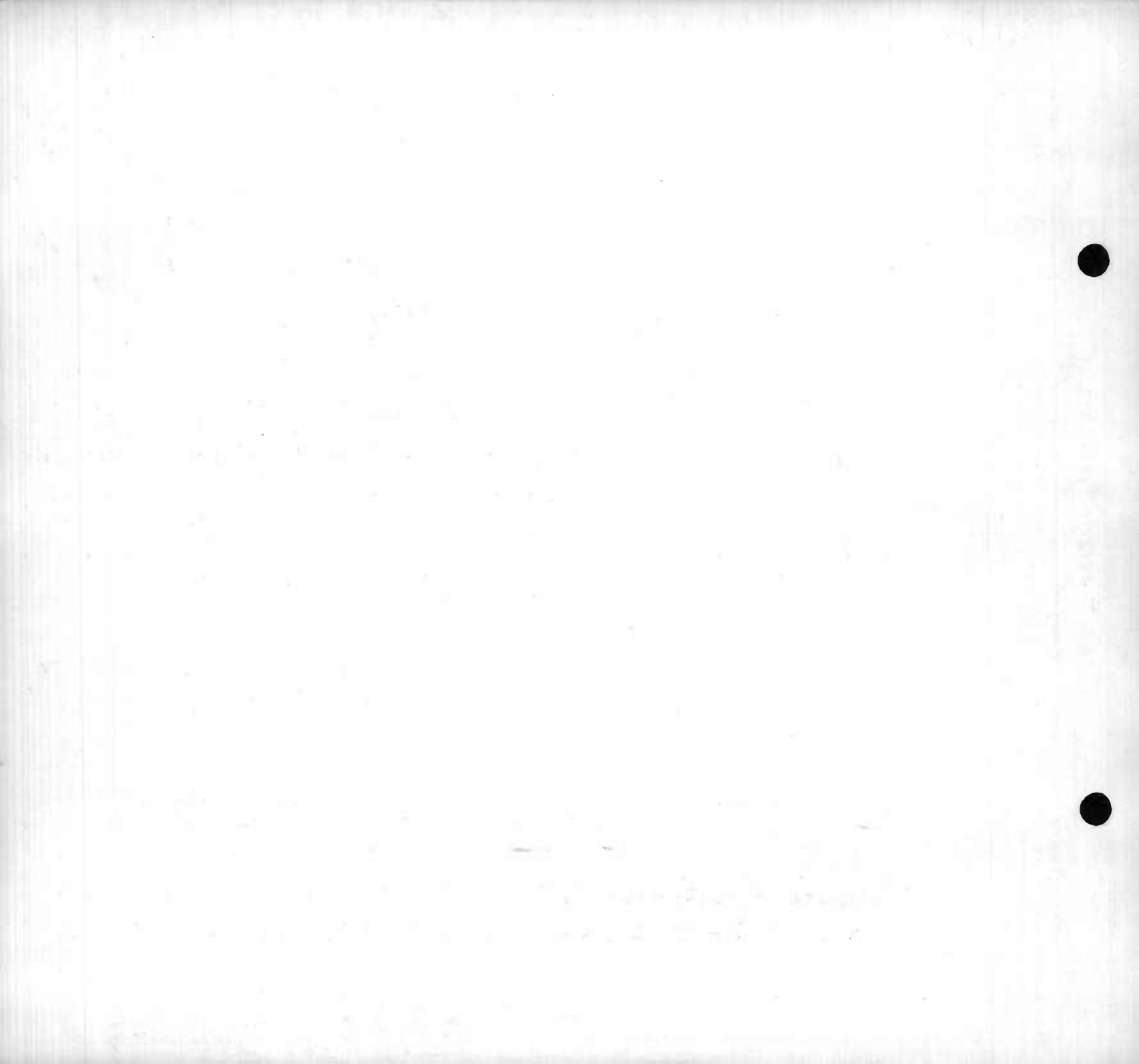
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. |
|--|---------------------|---|---------------------------------------|---|
| 69 5926 CERTIFICATE OF DEATH | | | | 69 5926 |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) WILLIAM H. KRAUSE (Krause) | | 2. DATE AND HOUR OF DEATH
6/10/69 455 P M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 1-03 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
HOUSE IN THE PINES BELAIRE
5837 BELAIR RD 21206 | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
637 S. BELNORD AVE 21224 | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/20/1884 | 9. AGE (In years last birthday)
84 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Lieutenant | | 10B. KIND OF BUSINESS OR INDUSTRY
Fire Department | | 11. BIRTHPLACE (State or foreign country)
Germany |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
219-22-4410 | | 17. INFORMANT
Mrs. Matilda H. Kruse |
| | | ADDRESS
637 S. Belnord Ave. | | |
| 18. CAUSE OF DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
1-378 I | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Lipo Loin Lobe Pneumonia | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF:
Cochyria | | | | |
| (C) Extensive Irregular Atherosclerosis of Arteries | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
weeks
3 mos. previous | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 6/10/1969 to 6/10/1969 , that (I) (we) last saw the deceased alive on 6/10/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Albert B. Bradley | | | | 23B. DATE SIGNED
6/10/69 |
| 23C. PHYSICIAN'S NAME (Type)
Albert B. Bradley | | | | 23D. ADDRESS
4900 Belair Road |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-13-1969 | | 24C. NAME OF CEMETERY OR CREMATORY
Oak Lawn |
| | | 24D. LOCATION
Baltimore County, Maryland | | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
JUN 11 1969 | | 25B. NAME OF REGISTRAR
Robert E. Jaber, M.D. | | 25C. FUNERAL DIRECTOR
Ellis & Keiler Inc. |
| | | | | ADDRESS
1901-07 Eastern Ave. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5927 | |
|---|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Monella Lovrance</i> | | 2. DATE AND HOUR OF DEATH
<i>June 6 1969 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>19-01</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>1302 Savatoga St
Baltimore</i> | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <i>Female</i> | | 6. RACE <i>C</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
<i>Aug 12-1903</i> | | 9. AGE (In years last birthday) <i>66</i> | | 10. If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Salisbury N.C.</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>unknown</i> | | 14. MOTHER'S MAIDEN NAME
<i>Parett</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Sottie Jett</i> | |
| 18. <i>404X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<i>Hypertensive Cardiovascular Disease</i> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>JF</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3-4 yrs</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-17</i> 19 <i>59</i> to <i>6-6-69</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>6-3-</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Maurice L. Adams M.D.</i> | | 23B. DATE SIGNED
<i>6-9-69</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>MAURICE L. ADAMS M.D.</i> | |
| 23D. ADDRESS
<i>238 N. Carey St Balt. Md</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6-12-69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Carew Memorial Park</i> | |
| 24D. LOCATION (City, town, or county)
<i>Lanham Md</i> | | 24E. SITE | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 11 1969</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taber, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Elmer Dickinson</i> | |
| ADDRESS
<i>1000 Brantley Ave</i> | | | | | |



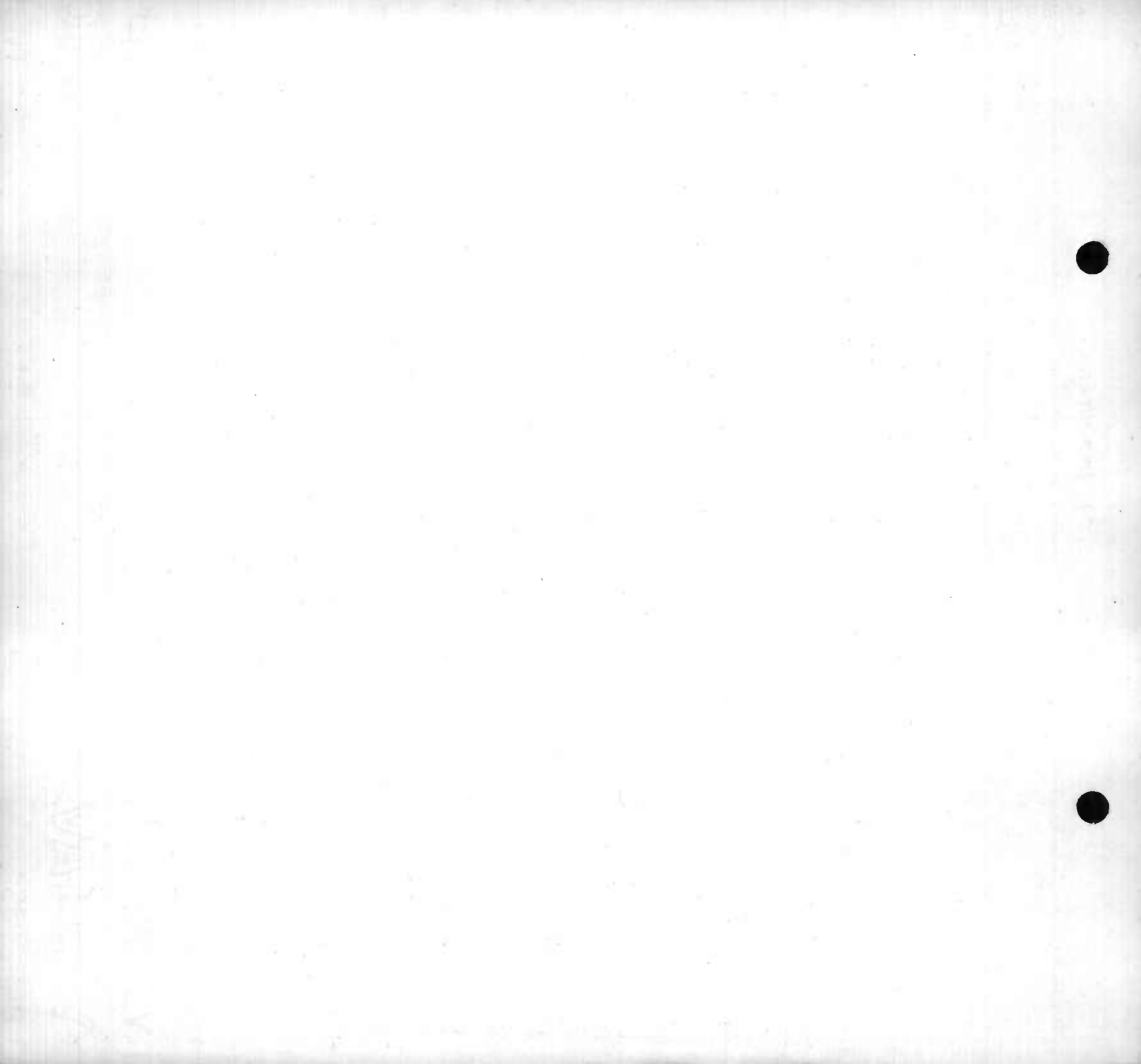
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

69 5928 CERTIFICATE OF DEATH

REG. NO. 69 5928

| | | | | | |
|--|---------|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Edie Sarah Richardson | | June 5 1969 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | |
| | | | | B. COUNTY | |
| 206 N Monastery Rd | | | | C. CITY OR TOWN | |
| | | | | D. INSIDE CITY LIMITS? | |
| | | | | E. STREET AND NUMBER | |
| | | | | 206 Monastery Rd | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| Female | C | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | Dec 18 1884 84 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | |
| Housewife | | | | 84 | |
| 13. FATHER'S NAME | | | | 11. BIRTHPLACE (State or foreign country) | |
| Robert Beale | | | | Maryland | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 14. MOTHER'S MAIDEN NAME | |
| No | | | | unknown | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | |
| | | | | Petra Damron | |
| | | | | ADDRESS | |
| | | | | Luis | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| 410.9 I | | (A) IMMEDIATE CAUSE | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Antecoronary Occlusion Sudden | | | |
| ANTECEDENT CAUSES | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Coronary Vascular Disease 15 years | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-16-65 to June 5 1969, that (I) (we) last saw the deceased alive on May 27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| William B. Watts | | | | 6-9-69 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| William H. Watts | | | | 1501 North Bond St | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 6-10-69 | | Mt Auburn Cmt | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUN 11 1969 | | Robert E. Fisher, M.D. | | Edie Richardson | |
| | | | | ADDRESS | |
| | | | | 206 Monastery Rd | |



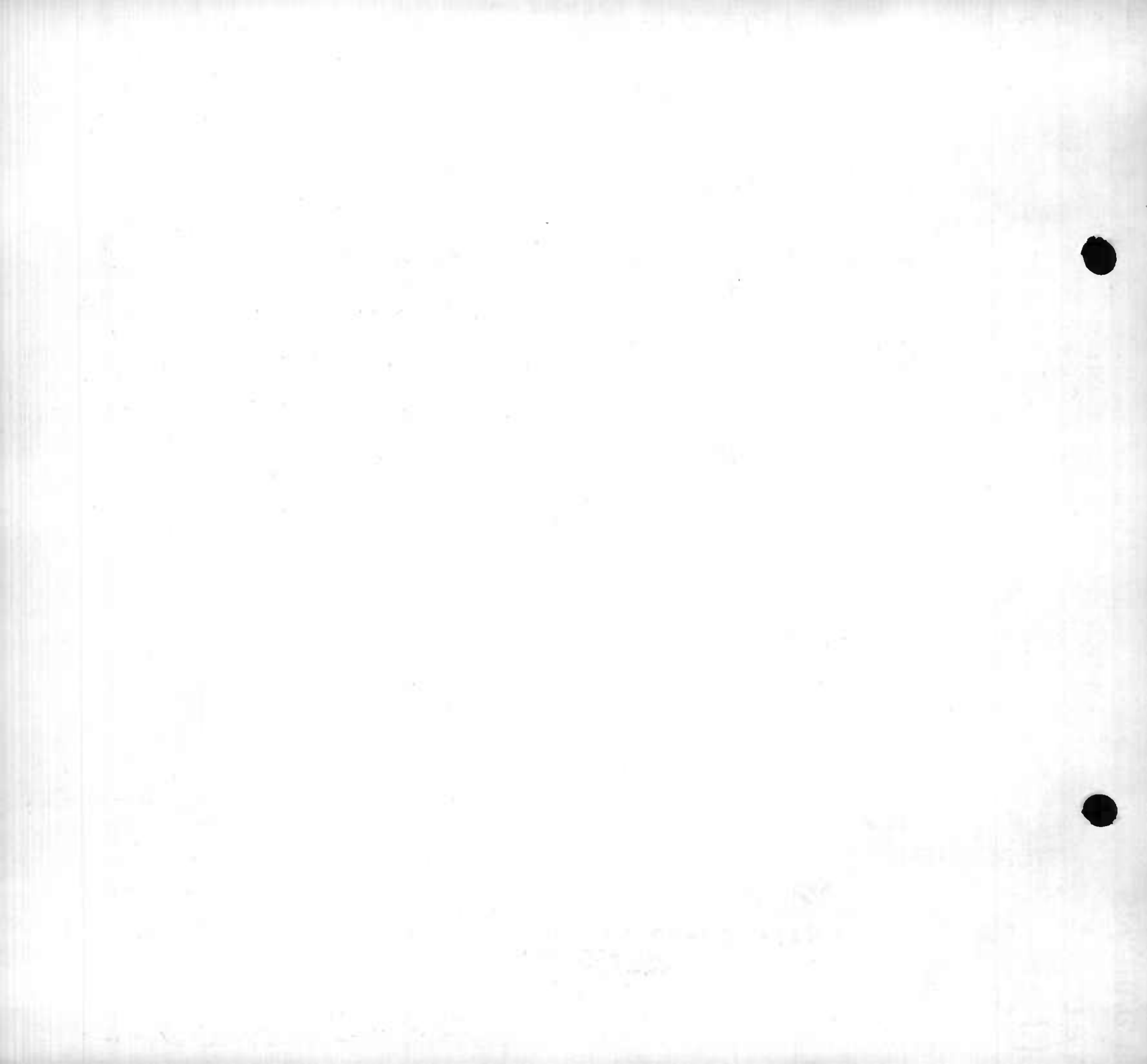
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5929 |
|---|----------------------|--|--|--|
| BIRTH NO. 69 5929 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Crutchfield Florence | | 2. DATE AND HOUR OF DEATH
June 10 1969 PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Lutheran hospital of Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 16-06 | | |
| | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
2836 Raynor Avenue | | |
| 5. SEX
F | 6. RACE
N. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-26-1878 | 9. AGE (In years last birthday) 91 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Baltimore Md | 12. CITIZEN OF WHAT COUNTRY?
U.S.A |
| 13. FATHER'S NAME
Robert Sorrell | | 14. MOTHER'S MAIDEN NAME
unknown Wing | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)
no | | 16. SOCIAL SECURITY NO.
67-28-2534 | 17. INFORMANT
Rachel Brown
ADDRESS same | |
| 18. 4124 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

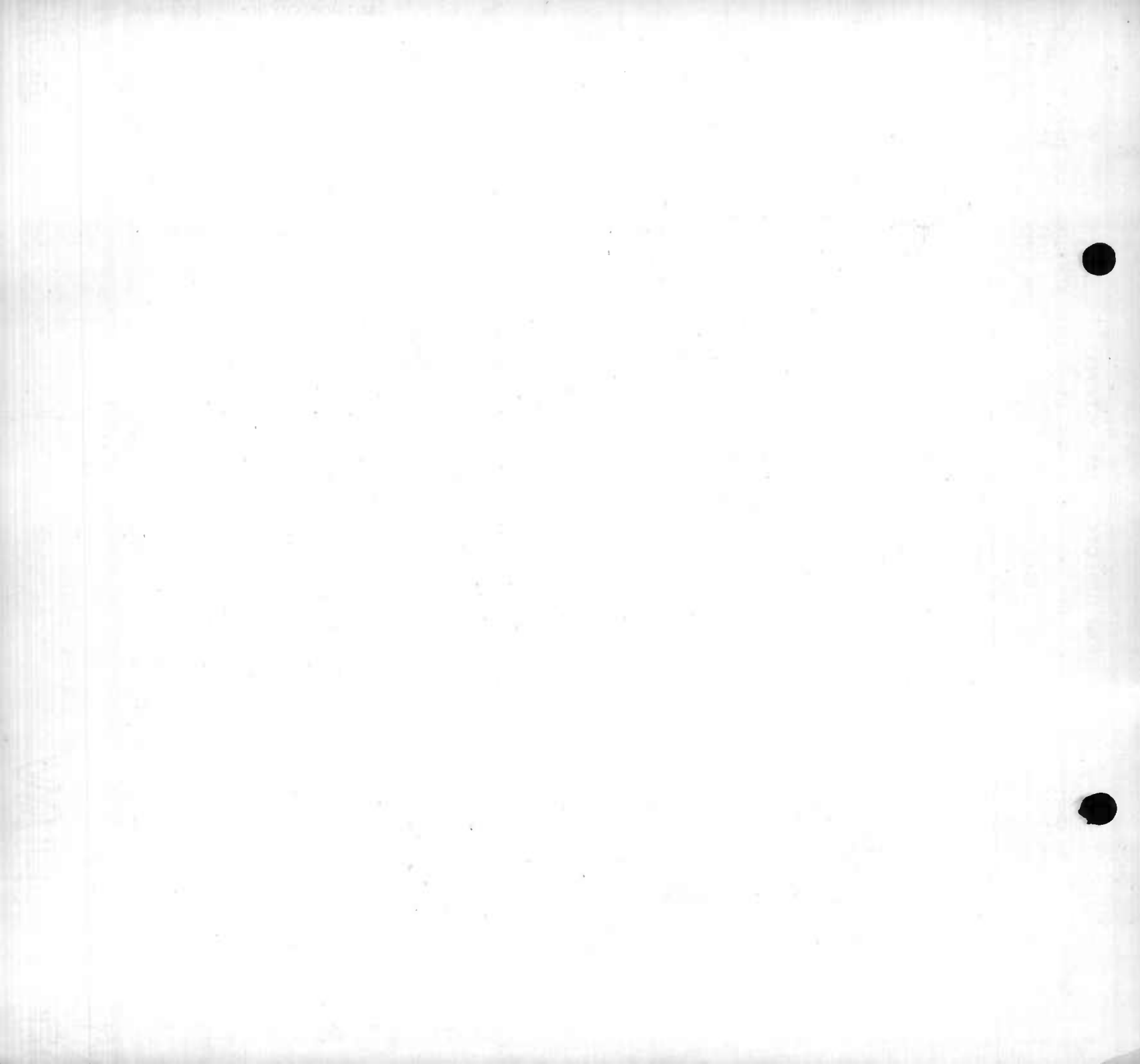
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
C.V.A
(B) ASCVD
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (X) (this hospital) attended the deceased from 6-9-69 19 to 6-10-1969 , that (I) (we) last saw the deceased alive on 12 noon 6-10-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Reta Bahadori m.d. | | 23B. DATE SIGNED
6-10-69 | | 23C. PHYSICIAN'S NAME (Type)
RETA BAHADORI M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-14-69 | | 24C. NAME OF CEMETERY or CREMATORY
Atlantic City Cal N Jersey |
| 24D. LOCATION (City, town, or county) (State)
N.J. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | |
| 25B. NAME OF REGISTRAR
Robert E. Gable, R.D. | | 25C. FUNERAL DIRECTOR
Bonadue Home N Jersey | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | 69 5920 |
|---|--------------|---|-----------------------------|---|---|----------|
| 69 5920 CERTIFICATE OF DEATH | | | | | | REG. NO. |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| | | Willie Douglas Jr. | | 6/4/69 4 ³⁰ P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNIVERSITY Hospital | | | | A. STATE
MD | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | B. COUNTY | | |
| 38 | | | | C. CITY OR TOWN
Baltimore | | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | E. STREET AND NUMBER
540 Dolphin St | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
2/14/16 | 9. AGE (In years last birthday)
53 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
NC | | |
| 13. FATHER'S NAME
James Douglas | | 14. MOTHER'S MAIDEN NAME
Ada Hooper | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes | | 16. SOCIAL SECURITY NO.
246-04-4038 | | 17. INFORMANT
Oda McIntosh - 325 Belmont Ave | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
250.9 I
arteriosclerotic heart disease | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
ASHD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Diabetes mellitus
DUE TO, OR AS A CONSEQUENCE OF:
years | | | | |
| (C) | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (this hospital) attended the deceased from 2 19 68 to 6 19 69, that (I) (we) last saw the deceased alive on May 9 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | |
| 23A. SIGNATURE
Allan C. Sidle | | | | 23B. DATE SIGNED
6/4/69 | | |
| 23C. PHYSICIAN'S NAME (Type)
Allan C. Sidle | | | | 23D. ADDRESS
MD UNIVERSITY HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
6-10-69 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Mt. View | | |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (State) | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | 25B. NAME OF REGISTRAR
Robert E. Haber, D.O. | | 25C. FUNERAL DIRECTOR
Roy Gibson 1070 Brantley Ave | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ALICE WALKER

ALICE WILMA MOORE WALKER

2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

June 6, 1969

6:45 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2103 E. Eager Street

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

June 6, 1969

6:15 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

7-03

6. SEX

Female

7. RACE

Negro

8. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

9-15-1926

10. AGE (In years last birthday)

40

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2103 E. Eager Street

11. BIRTHPLACE (State or foreign country)

Baltimore, N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jervis Moore

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

None

15. MOTHER'S MAIDEN NAME

Berice Green

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

No

17. SOCIAL SECURITY NO.

219-22-8013

18. INFORMANT

Berice Moore

ADDRESS

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Overside of Talwin

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) June 5, 1969 A.M. m.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2103 E. Eager Street

22F. HOW DID INJURY OCCUR?

Subject ingested overdose of Talwin

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/6/69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-11-69

24C. NAME OF CEMETERY or CREMATORY

Baltimore City

24D. LOCATION (City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 11 1969

25B. NAME OF REGISTRAR

James E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Eugene Wilson

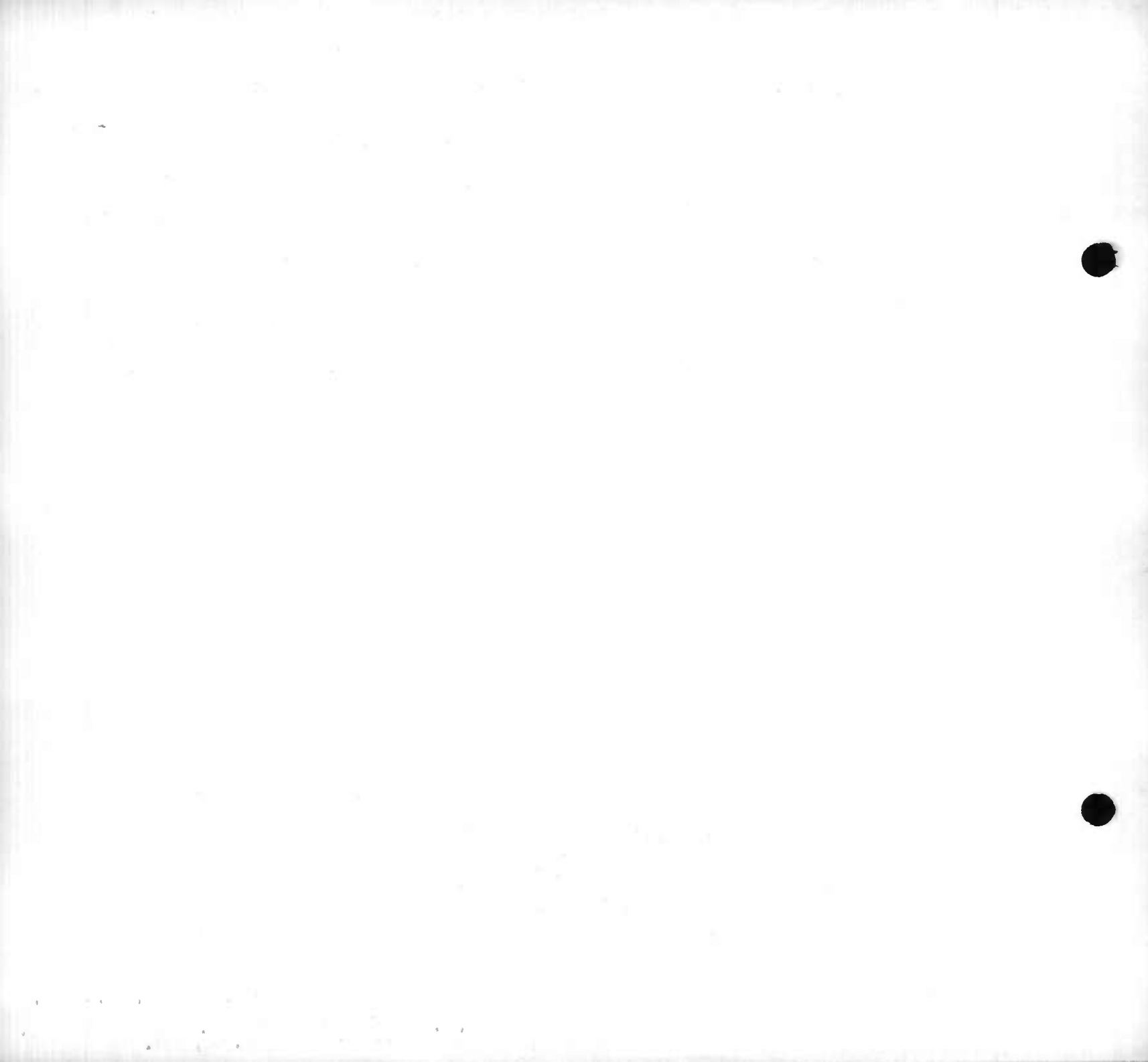
ADDRESS

1000 Montross St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

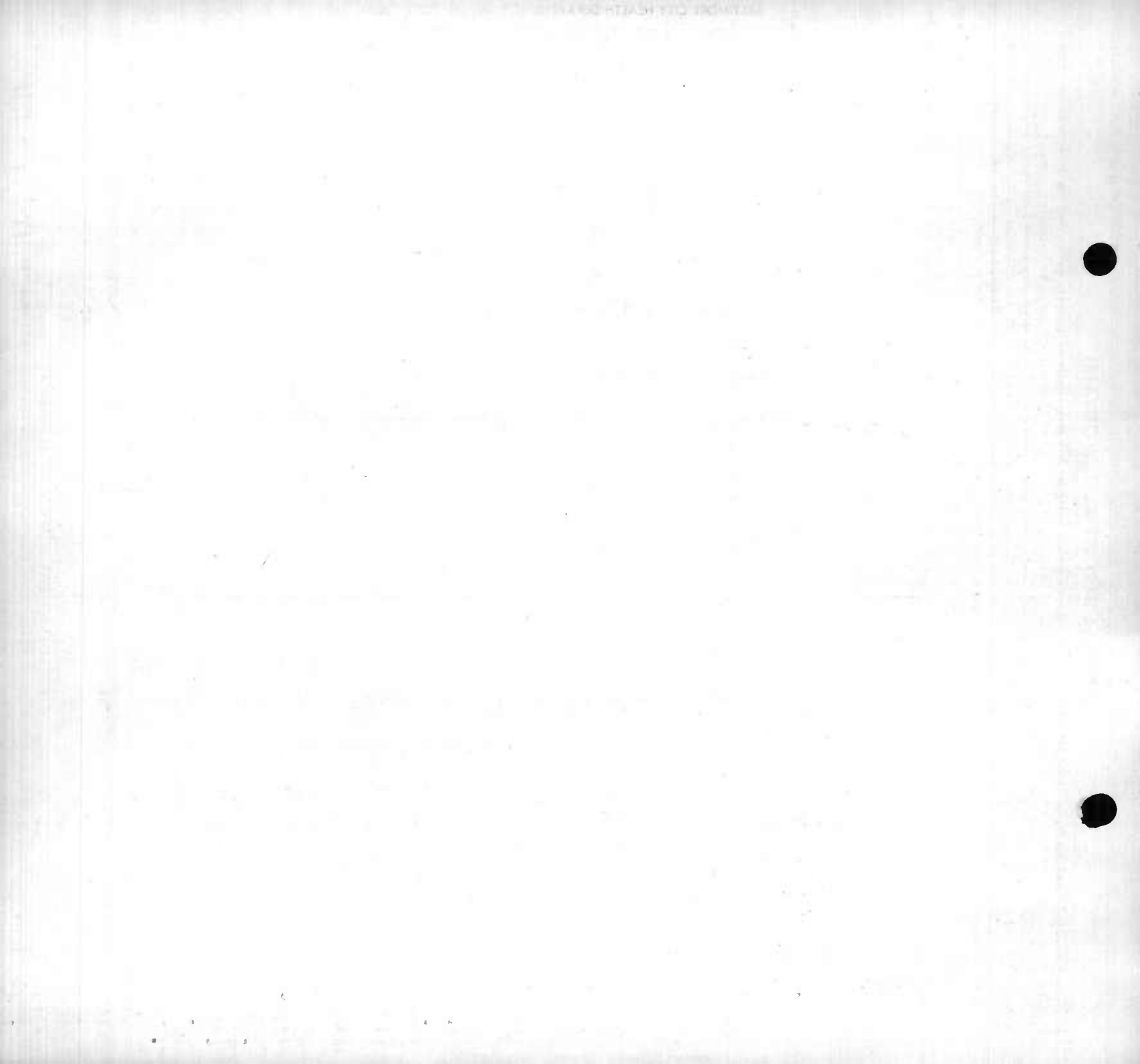
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | |
|--|--|---------------------|--|---|--|--|--|---|--|---|--|---|--|---|--|
| BIRTH NO. <i>Bulto Co. Md.</i> 5932 | | | | | | CERTIFICATE OF DEATH | | | | | | REG. NO. 69 5932 | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Katherine K. Allen</i> | | | | | | 2. DATE AND HOUR OF DEATH
<i>6-9-69</i> <i>3:55 A.M.</i> | | | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived; if institution; residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>Balto. Co.</i> | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Mercy Hospital</i> | | | | | | C. CITY OR TOWN
<i>Balto</i> | | | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | | E. STREET AND NUMBER
<i>1748 Glen Ridge Rd</i> | | | | | | | | | |
| 5. SEX
<i>F</i> | | 6. RACE
<i>W</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>6-10-66</i> | | 9. AGE (In years last birthday)
<i>2</i> | | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Child</i> | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | | | | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Malcolm M. Allen II</i> | | | | | | 14. MOTHER'S MAIDEN NAME
<i>Katherine Bond</i> | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | | | | | 16. SOCIAL SECURITY NO.
<i>—</i> | | 17. INFORMANT
<i>MOTHER</i> | | | | ADDRESS
<i>SAME, ABOVE</i> | | | |
| 18. <i>207.01</i> CAUSE OF DEATH | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>ACUTE FULMINANT</i> | | | | | | | | | | | | | | | |
| (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>PROMYELOCYTIC LEUKEMIA</i> | | | | | | | | | | | | <i>6 WEEKS</i> | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>6/9/69</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
[APPROX.] | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>6/9/69</i> to <i>6/9/69</i> that (I) (we) last saw the deceased alive on <i>6/9/69</i> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Eusebio P. Godines MD</i> | | | | | | | | | | | | 23B. DATE SIGNED
<i>6/9/69</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Eusebio P. Godines MD</i> | | | | | | | | | | | | 23D. ADDRESS
<i>90 MERCY HOSP, BALTO, MD 21202</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | | 24B. DATE
<i>6/11/69</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Druid Ridge</i> | | | | 24D. LOCATION (City, town, or county) (State)
<i>Pikesville, Balto. Co., Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR
<i>H. W. Jenkins</i> | | | | 25C. FUNERAL DIRECTOR
<i>H. W. Jenkins & Sons Co.</i> | | | | ADDRESS
<i>1905 York Rd. Balto. 12, Md.</i> | | | |



FUNERAL DIPECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|---|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) HARKER, Mr. GEORGE CORCORAN | | 2. DATE AND HOUR OF DEATH
6-9-69 5-55-P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
35 CHURCH HOME HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTIMORE | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
5101 UNDERWOOD RD (12) | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1-3-15 | 9. AGE (In years last birthday)
54 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MANAGEMENT ENVO ENTERPRISES | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
WISCONSIN | |
| 12. CITIZEN OF WHAT COUNTRY?
(AMER) 21 J.A. | | 13. FATHER'S NAME
GEORGE B. HARKER | | | |
| 14. MOTHER'S MAIDEN NAME
CATHERINE A. COCORAN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
398038907 | | 17. INFORMANT
(CHART) church home hosp | | | |
| 18. 17291
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTCEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Pulmonary edema | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
few hrs | |
| | | (B) Metastatic Melanoma
DUE TO, OR AS A CONSEQUENCE OF:
diffuse | | not known | |
| | | (C) _____ | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2/ | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 5-21-1969 to 6-9-1969 , that (H) (we) last saw the deceased alive on 6-9-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph Nidiry M.D. | | | | 23B. DATE SIGNED
6-10-69 | |
| 23C. PHYSICIAN'S NAME (Type)
JOSEPH NIDIRY M.D. | | | | 23D. ADDRESS
CHURCH HOME HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial-Rem. | | 24B. DATE
6/12/69 | | 24C. NAME of CEMETERY or CREMATORY
Calvary | |
| 24D. LOCATION
Beloit, | | 24E. LOCATION
Wisconsin | | 24F. LOCATION
1905 York Rd. Balto. 12, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | 25B. NAME OF REGISTRAR
E. J. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
H. W. Jenkins & Sons Co. | |

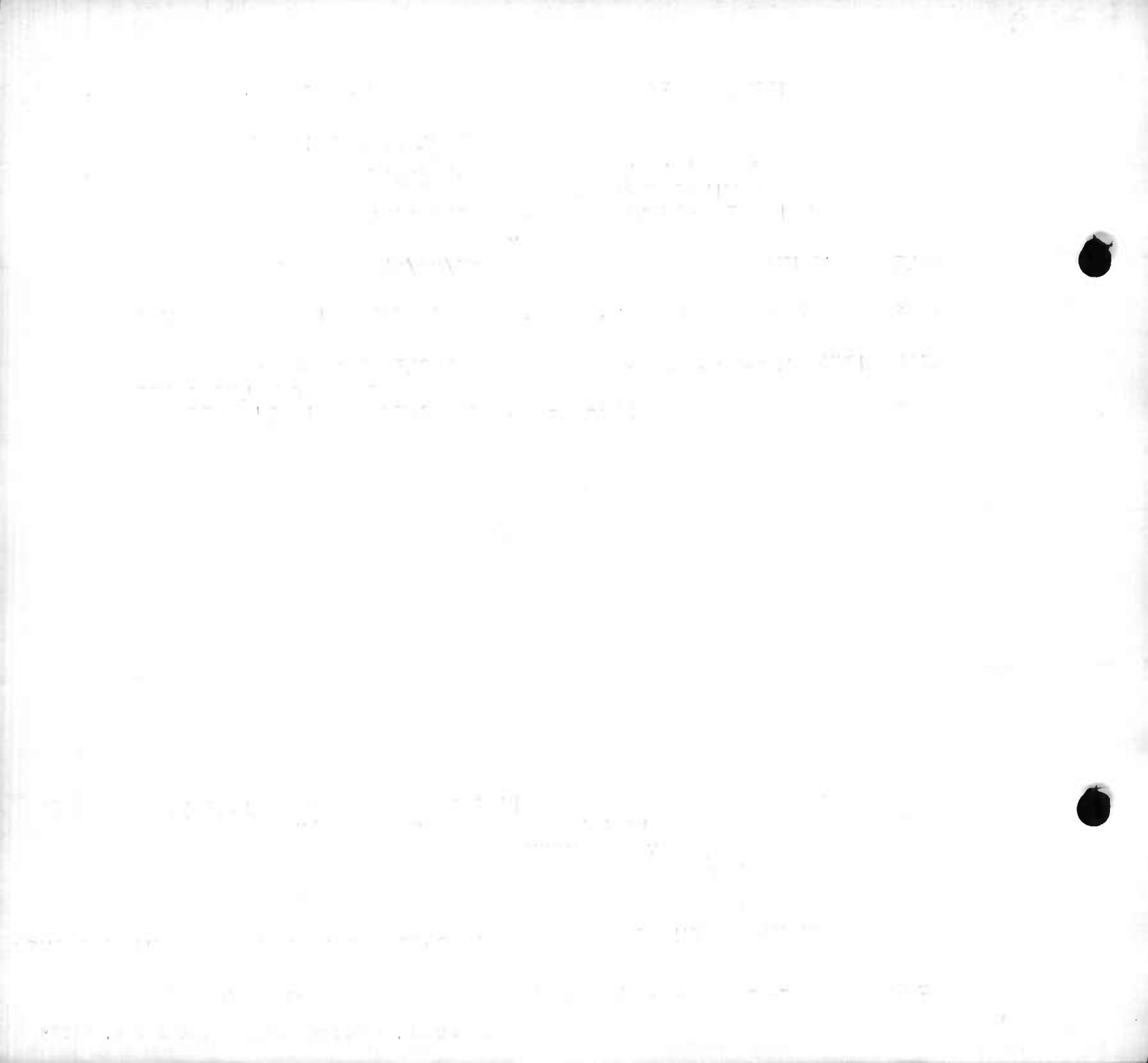


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

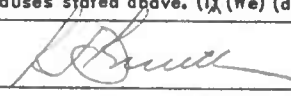
| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>69 5934</u> |
|---|------------------|---|--|---|
| BIRTH NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| RIZZA, JAMES A | | JUNE 7, 1969 1:00 AM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

40 ST AGNES HOSPITAL
CATON & WILKENS AVENUES
BALTIMORE, MARYLAND 21229 | | A. STATE
MARYLAND BALTIMORE | | |
| | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | E. STREET AND NUMBER
5911 OAKLAND ROAD | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
05/22/24 | 9. AGE (in years last birthday)
45 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Government Worker | | 10B. KIND OF BUSINESS OR INDUSTRY
Social Sec. Admin. | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
SAM RIZZA Sebastian Rizza | | 14. MOTHER'S MAIDEN NAME
ANGIE RIZZA Angeline Munson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
216-16-1360 | 17. INFORMANT
CATON & WILKENS AVES
ST AGNES HOSPITAL'S RECORDS | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Atherosclerotic Cardiovascular Disease</u>
(B) <u>Cerebro Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 1, 1969 to JUNE 7, 1969 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 7, 1969 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | |
| 23A. SIGNATURE
 | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type)
SALVADOR QUIROZ |
| 23D. ADDRESS
ST AGNES HOSPITAL CATON & WILKENS AVES | | 24. BURIAL CREMATION, REMOVAL (Specify) | | |
| Burial | | 24B. DATE
6-10-1969 | | |
| 24C. NAME of CEMETERY or CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
E. J. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|---|------------------------------|--|---|
| 69 5935 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | X REG. NO. 69 5935 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | GERTRUDE BARBARA O'SHEA | | JUNE 7, 1969 12:30 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

40 ST. AGNES HOSPITAL
CATON & WILKENS AVES.
BALTIMORE, MARYLAND 21229 | | A. STATE B. COUNTY
MARYLAND BALTIMORE CO. 21229 53-00 | | | |
| | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
4416 ALAN DR. APT D | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
06 08 00 | 9. AGE (in years last birthday)
68 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
NEW YORK | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
XXXXXXXXXXXXXXX Charles A. Miskimon | | | |
| 14. MOTHER'S MAIDEN NAME
V. MARY (MC DONOUGH) | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
213 05 2228 | | 17. INFORMANT AVER. BALTIMORE, MD. ADDRESS 21229
ST. AGNES HOSP RECORDS-CATON & WILKENS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ACUTE MYOCARDIAL INFARCTION | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
RESPIRATORY ARREST | | | |
| | | (B) CHRONIC OBST. PULM. DISEASE
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) _____ | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from <u>XXXX MAY 28</u> 19 <u>69</u> to <u>JUNE 7</u> 19 <u>69</u> that (IX) (we) last saw the deceased alive on <u>JUNE 7</u> 19 <u>69</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (IX) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | 23B. DATE SIGNED
6-7-69 | | 23C. PHYSICIAN'S NAME (Type)
RUDOLFO REVILLA, M.D. | |
| 23D. ADDRESS
21229 CATON & WILKENS AVES. - BALTIMORE, MD. | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | |
| 24B. DATE
6-10-69 | | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR, ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |



K-201 69 5936

CERTIFICATE OF DEATH

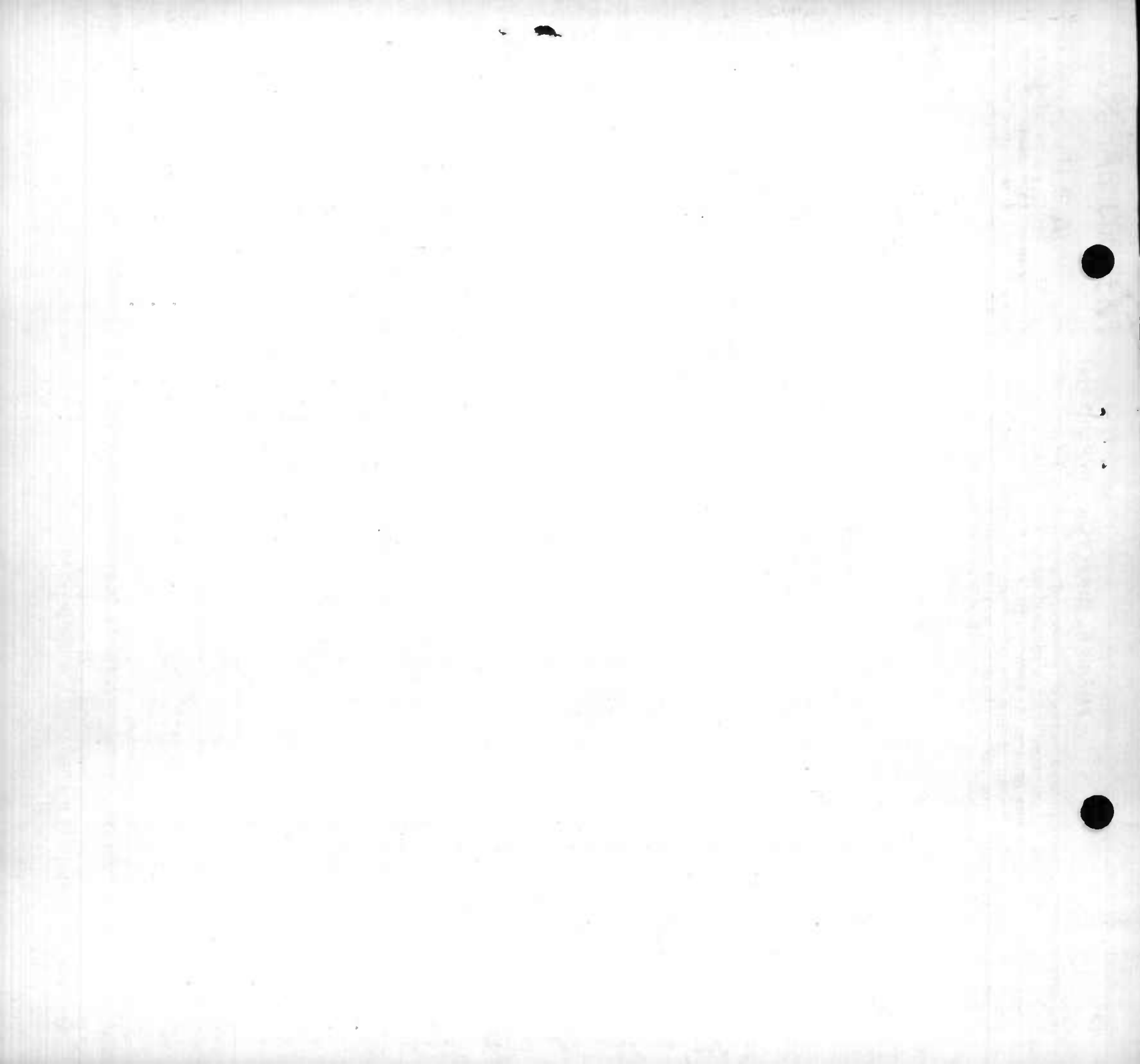
REG. NO. 69 5936

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) HELEN KECK
<i>Helen C. Keck</i> | | 2. DATE AND HOUR OF DEATH
6/7-1-69 <i>9:00 A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY 25-52 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE MARYLAND 21224 | | | | C. CITY OR TOWN BALTIMORE 21225
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
3211 CHERRYLAND ROAD BALTO, MD. 21225 | | | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-19-20 | 9. AGE (In years last birthday) 48 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic Worker | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
NORTH CAROLINA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
Roland Keck | | | 14. MOTHER'S MAIDEN NAME
Josephine | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
4940 EASTERN AVE. ADDRESS. MD.
BCH RECORDS BALTIMORE CITY HOSPITALS 21224
Gloria Early 3211 Cherryland Rd. | |
| 18. CAUSE OF DEATH
571.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(A) IMMEDIATE CAUSE <i>liver failure</i>
DUE TO, OR AS A CONSEQUENCE OF:
(B) chronic active hepatitis
DUE TO, OR AS A CONSEQUENCE OF:
(C)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 yrs.</i> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 6/1 1969 to 6/7 1969 , that (2) (we) lost saw the deceased alive on 6/7 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>DB Case M.D.</i>
DEGREE | | | | 23B. DATE SIGNED
6/7/69 | |
| 23C. PHYSICIAN'S NAME (Type)
David B. Case, M.D.
DEGREE | | | | 23D. ADDRESS
BCH 4940 EASTERN AVENUE BALTO. MD. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-11-69 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Cem. Park | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
James E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
V.R. Bailey
1348 Calhoun Street | |

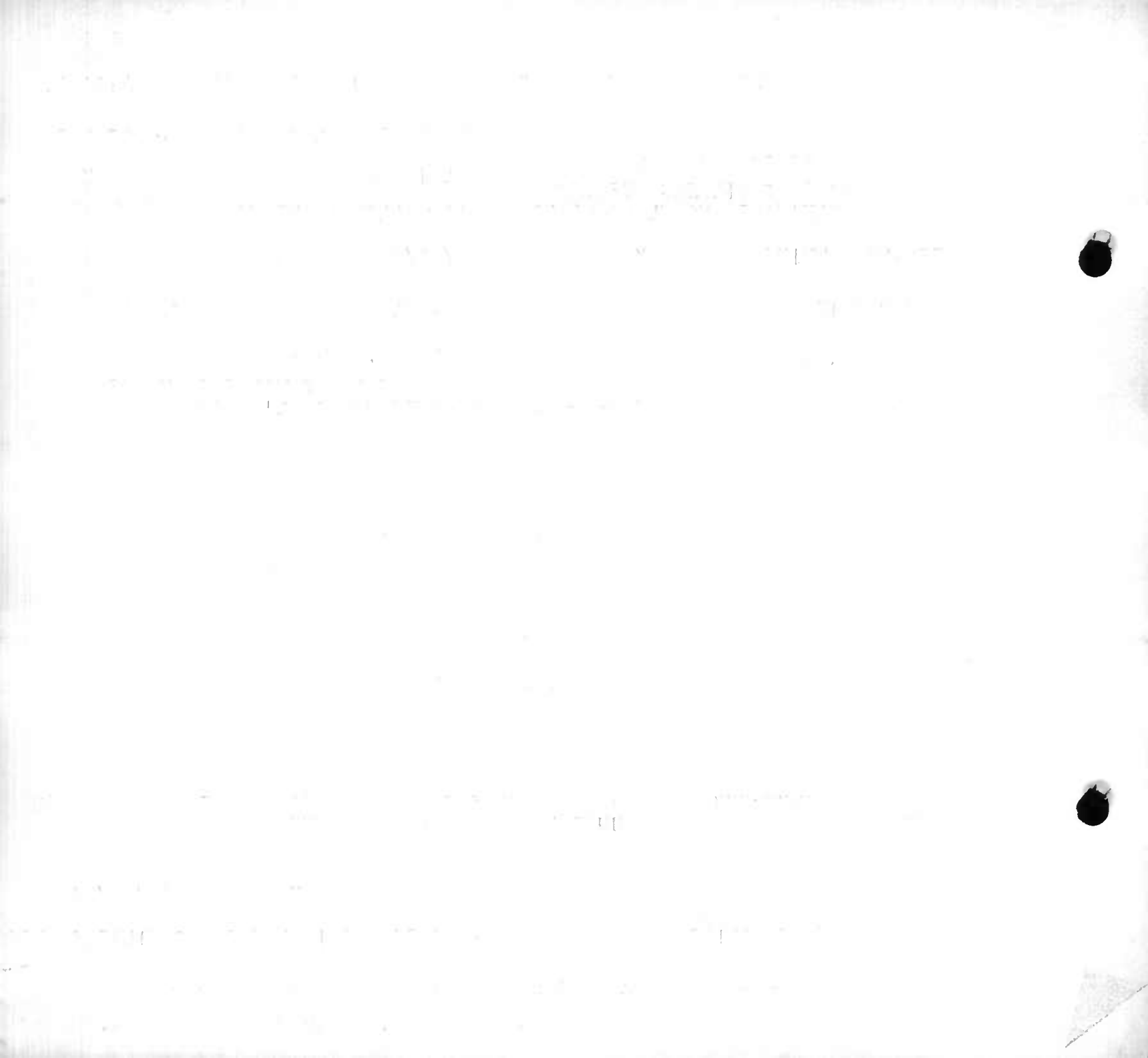
JUN 12 1969



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5937 |
|--|---|---|--|---|
| BIRTH NO. 69 5937 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| WEEDON, MARY THERESA | | JUNE 8, 1969 4:30 A. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 ST AGNES HOSPITAL
CATON & WILKENS AVENUES
BALTIMORE, MARYLAND 21229 | | A. STATE B. COUNTY
MARYLAND BALTIMORE 53-00 212227 | | |
| | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | E. STREET AND NUMBER
2110 ALLETTA AVENUE | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/07/99 | 9. AGE (In years last birthday)
69 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
JOHN H. RODGERS | | |
| 14. MOTHER'S MAIDEN NAME
CLARA C. MARTIN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | |
| 16. SOCIAL SECURITY NO.
219-38-6957 | | 17. INFORMANT
CATON & WILKENS AVENUES
ST AGNES HOSPITAL'S RECORDS | | |
| 18. CAUSE OF DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | |
| (A) IMMEDIATE CAUSE <u>ACUTE CORONARY OCCLUSION</u>
DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| (B) <u>ASCVD</u>
DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| (C) <u>DIABETES MELLITUS</u> | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>UMBILICAL HERNIA & INTEST. OBSTRUCTION</u> | | | | |
| 19A. DATE OF OPERATION
6-5-69 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
INCARCERATED <u>UMBILICAL HERNIA</u> | 20A. AUTOPSY? (Yes or No)
NO | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (We) XXXXXX attended the deceased from <u>JUNE 5</u> 19 <u>69</u> to <u>JUNE 8</u> 19 <u>69</u> that XX (we) last saw the deceased alive on <u>JUNE 8</u> 19 <u>69</u> and that XXXXXX (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>M. Cabiling</u> | | 23B. DATE SIGNED
06/08/69 | | 23C. PHYSICIAN'S NAME (Type)
M. CABILING, M.D. |
| 23D. ADDRESS
ST AGNES HOSPITAL CATON & WILKENS AVES | | 23E. DEGREE | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE
6-11-69 | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Park Cemetery | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | 25B. NAME OF REGISTRAR
<u>Robert E. Fabel, M.D.</u> | 25C. FUNERAL DIRECTOR
Howard H. Hubbard 4107 Wilkens Ave. 21229 | | |

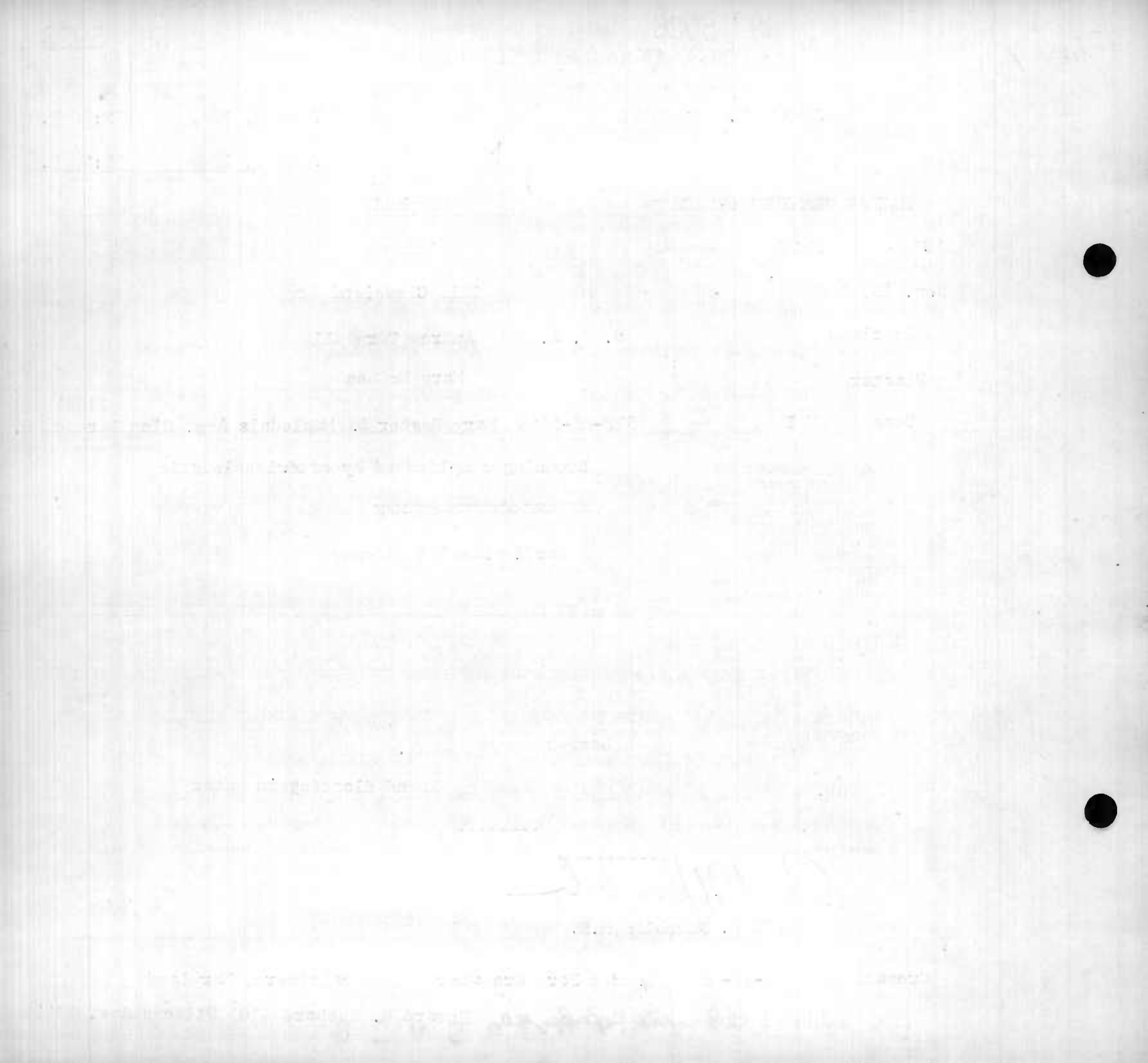


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

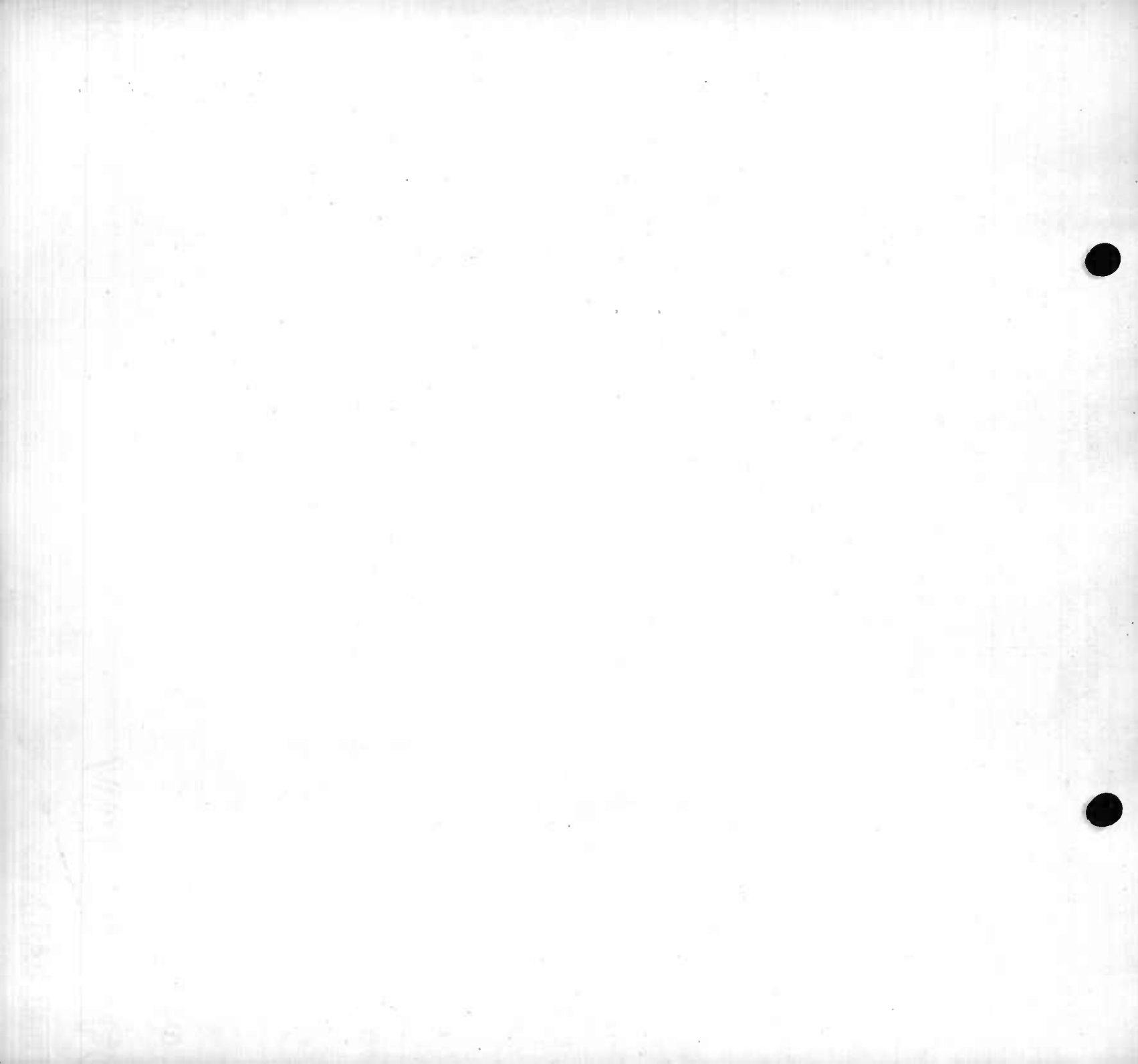
| | | | | | |
|---|-------------------------|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
JAMES M. TURNBULL | | | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 8, 1969
Hour 12:20 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
07 MEDICAL EXAMINER OFFICE | | | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 8, 1969 12:20 P.M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 21-02 | | | | | |
| 6. SEX
Male | 7. RACE
White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
Nov. 15, 1888 | | 10. AGE (In years lost birthday) 80 | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 11. BIRTHPLACE (State or foreign country)
Scotland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | E. STREET AND NUMBER
1216 Cleveland Street | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Plaster | | 14B. KIND OF BUSINESS OR INDUSTRY | | 13. FATHER'S NAME
Andrew Turnbull | |
| 15. MOTHER'S MAIDEN NAME
Mary McGhee | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW I | | 17. SOCIAL SECURITY NO.
578-05-5146 | |
| 18. INFORMANT
Mary Huster | | ADDRESS
55 Mapledale Ave. Glen Burnie Md. | | 21061 | |
| 19. E910.7
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Drowning complicated by arteriosclerotic
(A) IMMEDIATE CAUSE
due to or as a consequence of
(B) cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 21. AUTOPSY? (Yes or No)
yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
<input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
harbor | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Unk. | |
| 22D. TIME OF INJURY (APPROX.)
Unk. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Found floating in water | |
| 23.
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D.
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 6 /9/69 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
6-10-69 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Crematory | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 11 1969 | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard | |
| ADDRESS
4107 Wilkens Ave. 21229 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 69 5939 | | REG. NO. 69 5939 | |
|---|-------------------------|---|--|---|--|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) <i>William D. Gardner</i> | | | |
| 2. DATE AND HOUR OF DEATH
<i>June 8, 1969 8:25 p.</i> M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>7-02</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>33 Johns Hopkins Hospital</i> | | | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<i>500 N. Belnord Avenue</i> | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>9-14-91</i> | 9. AGE (In years last birthday)
<i>77</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Metalworker</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Mfg. Co.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | | | | |
| 13. FATHER'S NAME
<i>George Gardner</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Florence Smith</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Yes WW I</i> | | | | 16. SOCIAL SECURITY NO.
<i>217 09 7840</i> | | 17. INFORMANT ADDRESS
<i>Elsie Bucking 529 N. Belnord Avenue</i> | |
| 18. <i>412.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>Cardio-renal vascular disease</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>?</i> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>chronic coronary artery disease, angina, generalized atherosclerosis, hypertension</i> | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept 1965</i> to <i>June 8 1969</i> , that (I) (we) last saw the deceased alive on <i>May 28 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>L. C. Dobihal</i> | | | | 23B. DATE SIGNED
<i>6/10/69</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>L. C. Dobihal</i> | | | | 23D. ADDRESS
<i>M. D. 447 N. Kenwood Ave. Balto, Md. 21224</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>6-12-69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Baltimore Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 11 1969</i> | | 25B. NAME OF REGISTRAR
<i>Robert S. J. [illegible]</i> | | 25C. FUNERAL DIRECTOR
<i>[illegible]</i> | | ADDRESS
<i>1211 Chesaco Avenue</i> | |

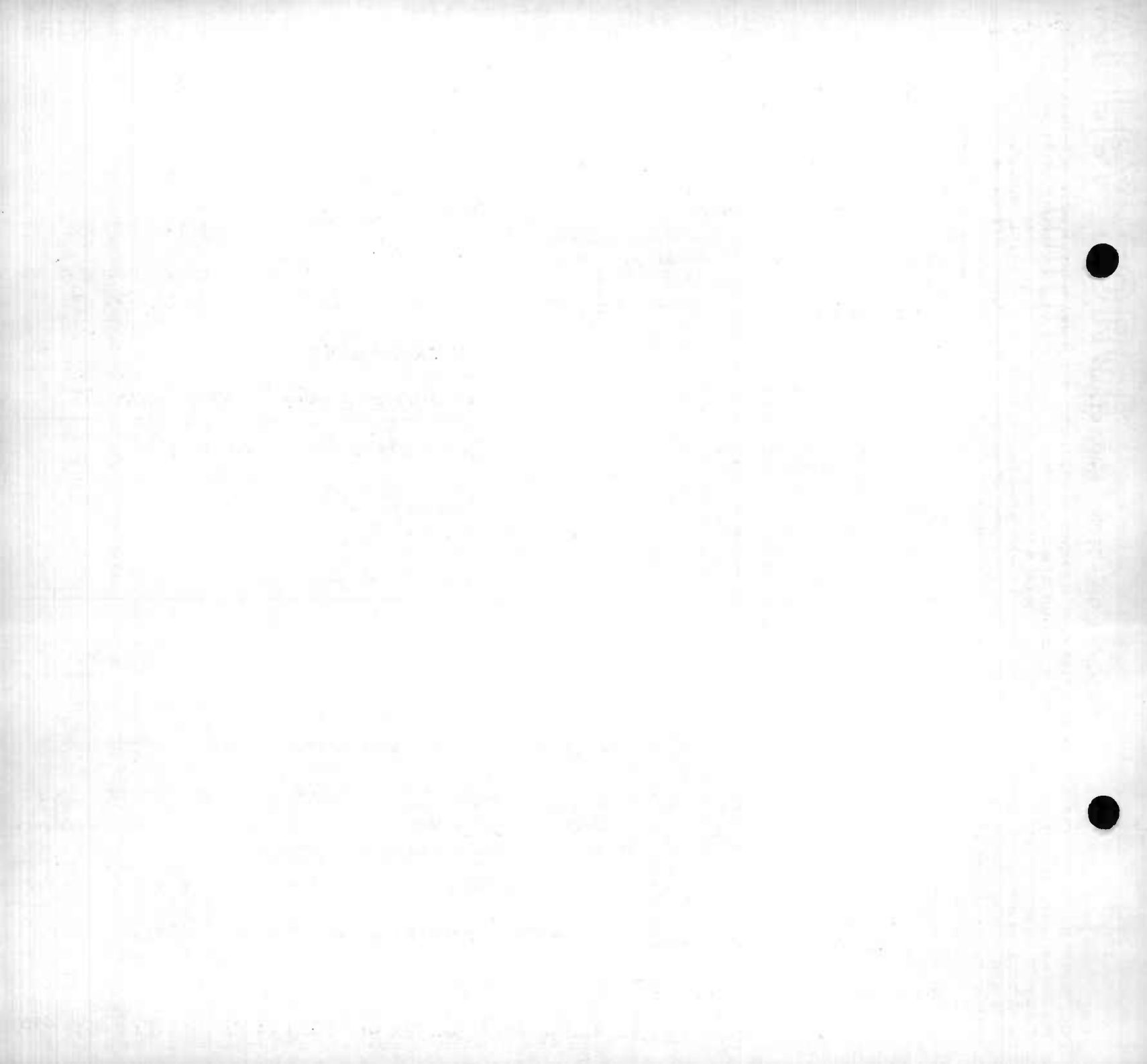


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5940</u> |
|---|---|---|--|---|
| BIRTH NO. | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type in Print) <u>Wesch Carl E. Jr.</u> | | 2. DATE AND HOUR OF DEATH
<u>6-8-69 - 5⁴⁵ PM</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>25+34</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>90 MT. SINAI NURSING HOME</u> | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER
<u>BALTO. MD. 402 Jack Street</u> | | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-26-1900</u> | 9. AGE (In years lost birthday)
<u>69</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>CHAUFFEUR</u> | | 11. BIRTHPLACE (State or foreign country)
<u>NEW YORK</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | | |
| 13. FATHER'S NAME
<u>CARL WESCH</u> | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>-</u> | | 17. INFORMANT
<u>MADELINE CREW</u> |
| 18. <u>25-091</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>CONGESTIVE HEART FAILURE</u> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>Diabetes Mellitus</u>
<u>N.C.V.D.</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<u>Brain Squeeze</u>
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 mo</u>
<u>2 yrs</u>
<u>1 mo</u> |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/5</u> <u>1969</u> to <u>6/8</u> <u>1969</u> , that (I) (we) last saw the deceased alive on <u>6/8</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Edward S. Hallins MD</u> | | | | 23B. DATE SIGNED
<u>6/8/69</u> |
| 23C. PHYSICIAN'S NAME (Type)
<u>EDWARD S. KALLINS MD</u> | | 23D. ADDRESS
<u>6000 PARK HTS Dr. Baltimore Md</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 24B. DATE
<u>6-12-69</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>ODD FELLOWS CEMT</u> | 24D. LOCATION (City, town, or county) (State)
<u>SMYRNA KENT DEL.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR
<u>John E. Taylor, R.D.</u> | 25C. FUNERAL DIRECTOR
<u>VICTOR W. KENNEDY</u> | | |
| | | ADDRESS
<u>STILL POND, MD.</u> | | |

JUN 11 1969



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

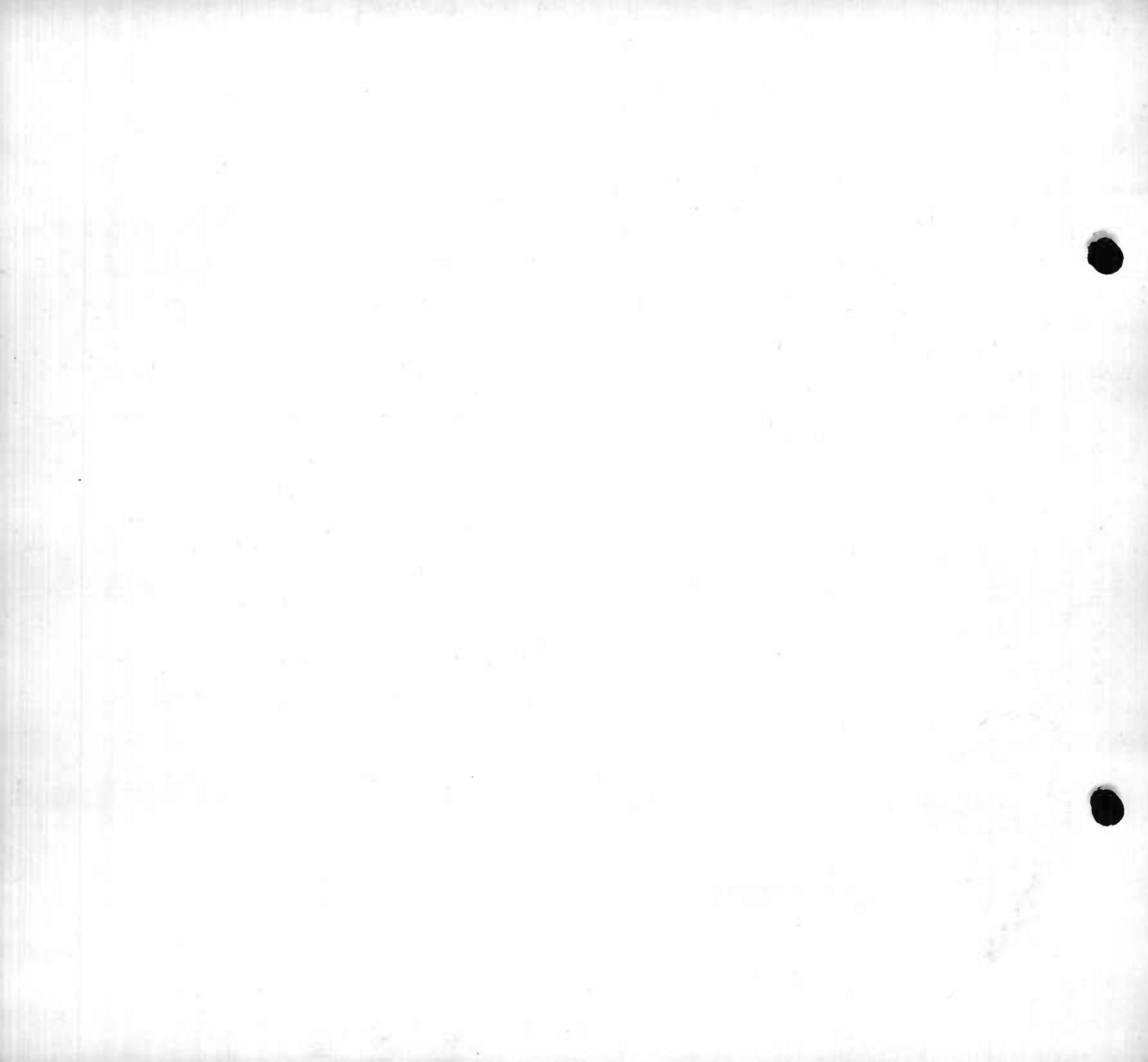
BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 5941

| | | | | | |
|--|----------------------|---|---|--|--|
| BIRTH NO. 69 5941 | | CERTIFICATE OF DEATH | | REG. NO. 69 5941 | |
| 1. NAME OF DECEASED
(Type or Print) <i>Bonsall Frances A.</i> | | | 2. DATE AND HOUR OF DEATH
<i>6/9/69 6:05 PM.</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>34 Bon Secours Hospital</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN <i>BALTO.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>3303 Fernside Ave. 21207</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11/2/1892</i> | 9. AGE (In years last birthday) <i>76</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Scamstresses</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> |
| 13. FATHER'S NAME
<i>Nicholas Batz</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Mary Wonder</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
<i>Charles E. Bonsall, Sr. - Same</i> | | |
| 18. <i>579312</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>removal of gallbladder and heart disease.</i>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>5, 21, 69 To 6/9, 69</i> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5-31-68</i> 19 <i>68</i> to <i>6-9</i> 19 <i>69</i> , that (we) last saw the deceased alive on <i>6-2-69</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>DARA B.</i> | | | | | |
| 23A. SIGNATURE
<i>DARA B.</i> | | | 23B. DATE SIGNED
<i>6/9/69</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>Dr. Darabi</i> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 24B. DATE
<i>6-13-69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>New Cathedral Cemetery - BALTO, Md.</i> |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 11 1969</i> | | | 25B. NAME OF REGISTRAR
<i>Robert E. Jones, MD.</i> | | 25C. FUNERAL DIRECTOR
<i>SAFARIAN & FUNERAL CHAPEL - LIBERTY HEIGHTS</i> |



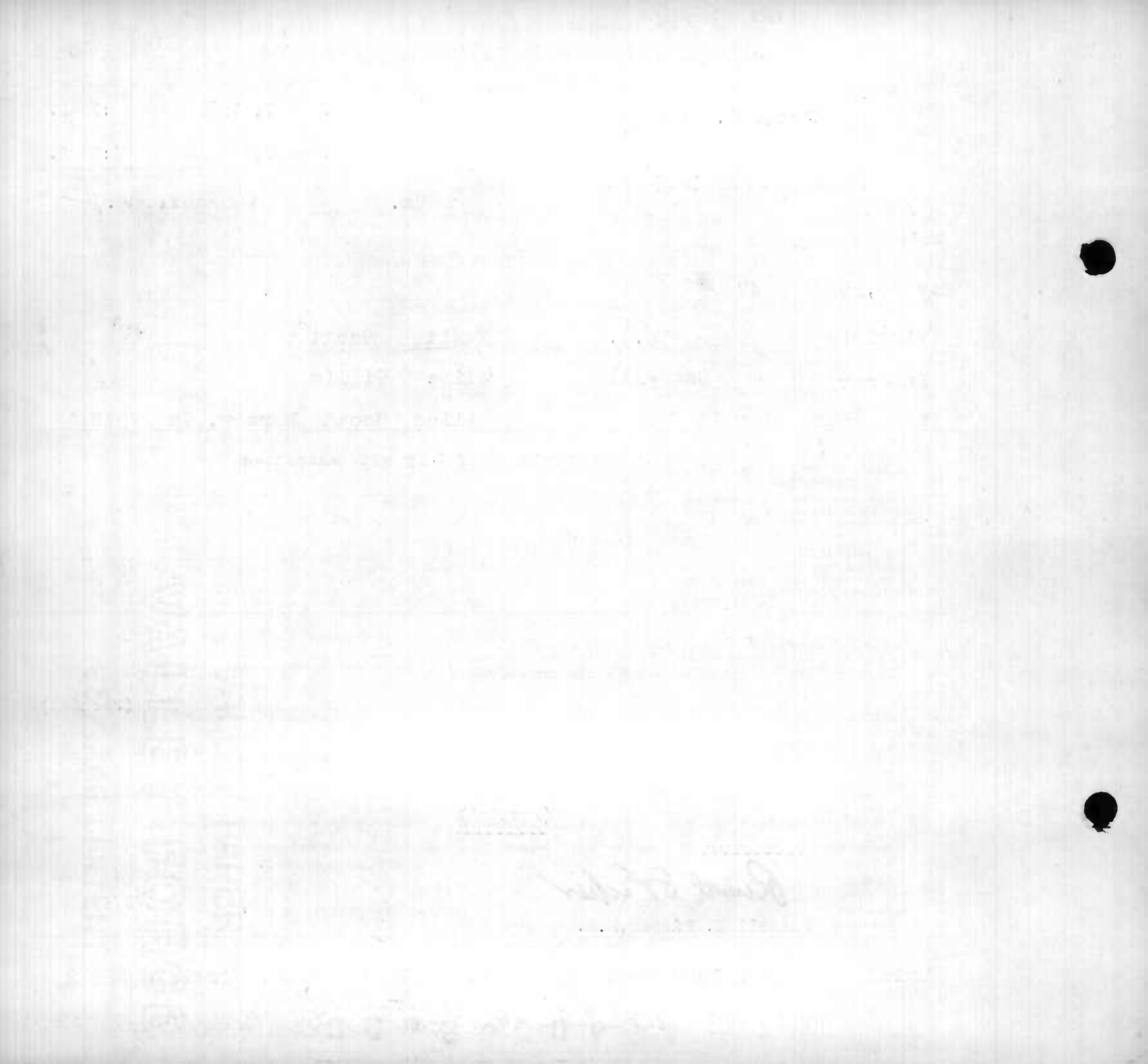
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5942

BIRTH NO.

| | | | |
|---|-------------------------|--|--|
| 1. NAME OF DECEASED
(Type or Print)
LESTER E. SCOTT | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 7, 1969
Hour 6:30 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
MERCY HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 7, 1969
Hour 6:30 P. M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE ? Va.
B. COUNTY Richmond, Co. V-43 | | C. CITY OR TOWN
?
D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX
Male | 7. RACE
Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
May 30, 1922 | | 10. AGE (In years lost birthday) 47
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY
Saw Mill | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes World War II ? | | 17. SOCIAL SECURITY NO.
? | |
| 18. INFORMANT
Alice Scott | | ADDRESS
Warsaw, Va 22572 | |
| 19. 162.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Carcinoma of lung with metastases | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | |
| 20. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> (Partial) Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Russell S. Fisher M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | DATE SIGNED
6/8/69 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/12/1969 | |
| 24C. NAME OF CEMETERY or CREMATORY
Scott Town Pvt. Cemetery | | 24D. LOCATION (City, town, or county) (State)
Warsaw, Virginia 22572 | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, R.D. | |
| 25C. FUNERAL DIRECTOR
Eugene W. Lee | | ADDRESS
King George Va. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5943

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) HOWARD RAYMOND BUCKALEW | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 8, 1969 Hour 2:10 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
CITY HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 8, 1969 2:10 A.M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
11/12/1933 | | 10. AGE (In years last birthday) 35 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steel Mill | | 14B. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 1961-1963 | | 17. SOCIAL SECURITY NO.
214-30-7467 | |
| 19. E955 X 214-30-7463 | | 18. INFORMANT
Joann V. Buckalew | |
| 15. MOTHER'S MAIDEN NAME
Mary K. Dick | | ADDRESS 112 North Janney St. | |
| 13. FATHER'S NAME
Raymond Buckalew | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19. E955 X 214-30-7463 | | CAUSE OF DEATH
Contact gunshot wound of left chest | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Alley in car | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)
June 8, 1969 12:30 A.M. | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
Alley rear of 112 N. Janney Street | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Self-inflicted gunshot wound of chest | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| ACTUAL SIGNATURE Russell S. Fisher M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/14/69 | |
| 24C. NAME OF CEMETERY or CREMATORY
I.O.O.F. Mc Garden | | 24D. LOCATION (City, town, or county) (State)
Mineral Co. W. Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
Shayler & Fisher | | 25D. ADDRESS
1930 Eastern Ave. Baltimore, Md. | |

VS 153 6-19-69 M.H.

CERTIFICATE AFFIDAVIT

By
1/1/69

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5944

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5944

| | | | | | |
|--|--|--|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) CZAJKOWSKI, ANNA | | 2. DATE AND HOUR OF DEATH
5/27/69 10⁰⁰ A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
The Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE Maryland B. COUNTY 6-04 | | |
| 5. SEX Female | | | 6. RACE XXXXXX white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH
10/11/06 | | 9. AGE (In years last birthday) 62 | | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| 12. CITIZEN OF WHAT COUNTRY | | | 13. FATHER'S NAME | | |
| 14. MOTHER'S MAIDEN NAME | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatic Comma

(B) LABONNEC'S Cirrhosis
DUE TO, OR AS A CONSEQUENCE OF:

(C) | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1-2 days

yes. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No. | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 27 19 69 to May 27 19 69 that (I) (we) last saw the deceased alive on 5/27/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. D. Hank JR. M.D. | | 23B. DATE SIGNED 5/27/69 | | 23C. PHYSICIAN'S NAME (Type) Edward D. Hank JR. M.D. | |
| 23D. ADDRESS 1519 ANATOMY BOARD OF MARYLAND | | 23E. UNIVERSITY MEDICAL SCHOOL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 6/6/69 | | 24C. NAME of CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. MORTUARY SERVICE - BCHD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Fausberg M.D. | | 25C. FUNERAL DIRECTOR ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 5945 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5945 | |
|---|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Allen Harris | | | | 5-31-69 2:30 p. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | |
| 39 Provident Hospital, Inc.
1514 Division Street
Baltimore, Maryland 21217 | | | | Maryland | | 14-02 | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sep | |
| Male | | | | Negro | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | |
| | | | | | | 60 | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Virginia | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | | Miss M. Johnson - Friend | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | (A) IMMEDIATE CAUSE | | Pulmonary Embolism | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | 3 days | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | 25 days | |
| | | | | (C) Severe pulmonary emphysema | | 10 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | ASCVD | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 15-19-69 | | Good | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | Home | | 1631 Pennsylvania ave | | 14-02 | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour)
5-6-69 | | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | Fell down | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 6, 19 69 to May 31, 19 69 that (I) (we) last saw the deceased alive on May 31, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| P. Chotikul M.D. | | | | 6-2-69 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| POCHNA CHOTIKUL | | | | 1514 Division St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION | |
| | | 6/5/69 | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |
| JUN 12 1969 | | J. E. J. M.D. | | MORTUARY SERVICE - BCHD | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
RICHARD BLACK | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> May 1, 1969 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
517 Cathedral Street | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
May 1, 1969 12:05 P.M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 11-02 | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday)
46 | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT | | ADDRESS | |

| | | | |
|---|--|---|--|
| 19. 571.81
CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE Fatty metamorphosis of liver
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |

| | | | | | |
|--|--|---|--|--|--|
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
Yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |

| | | | | | |
|---|--|--|--|--------------------|--|
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| ACTUAL SIGNATURE Charles S. Springate M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | May 1, 1969 | |

| | | | | | |
|---|--|---|--|---|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
6/10/69 | | 24C. NAME of CEMETERY or CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
John E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD | |

WILLEY 4001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69-20381 69 5947 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5947 | |
|--|-------------------------|--|------------------------------------|---|---|--|--|
| 1. NAME OF DECEASED
(Type or Print) Baby Girl Brown | | | | 2. DATE AND HOUR OF DEATH
5/28/69 10 a. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
43 SOUTH BALTIMORE GENERAL HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 914 Bethune Road #21225 | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/28/69 | | 9. AGE (In years last birthday)
Born at Home. | 10. Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min.
2 3 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME
Belinda Brown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. II
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE IMMATURITY
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | |
| MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION
D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/28/69 19 to 5/28/69 19 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 5/28/69 19 and that In <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
H. E. Mendelsohn, M.D. | | | | 23B. DATE SIGNED
6/6/69 | | 23C. PHYSICIAN'S NAME (Type)
H. E. Mendelsohn, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
6/9/69 | | 24B. DATE
6/9/69 | | 24C. NAME OF CEMETERY or CREMATORY
ANATOMY BOARD OF MARYLAND | | 24D. LOCATION
UNIVERSITY MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | | 25D. ADDRESS | |

unknown

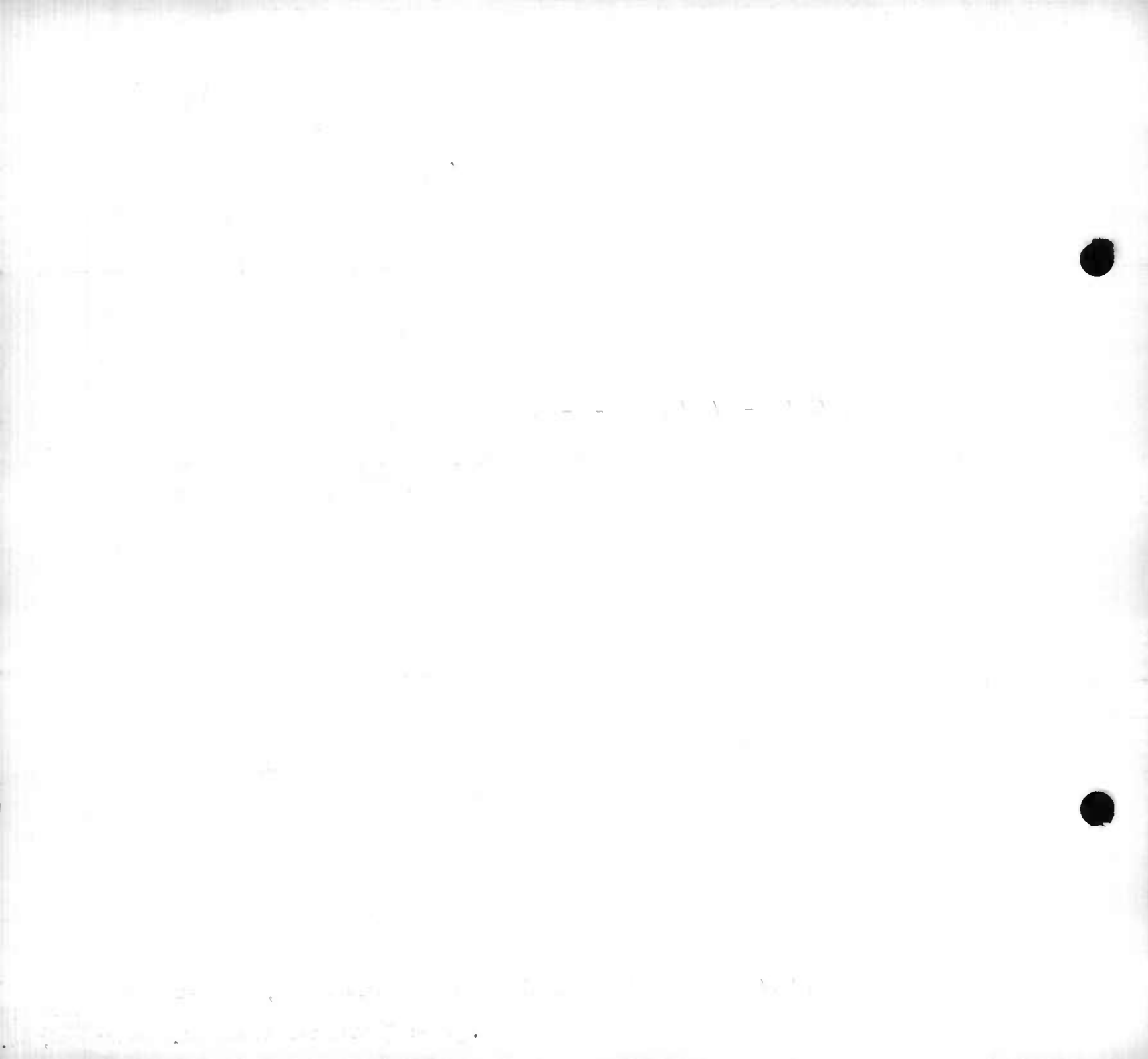
6/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5948 CERTIFICATE OF DEATH X REG. NO. 69 5948

| | | | | | |
|---|----------------------|---|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) James E. McKenney | | 2. DATE AND HOUR OF DEATH
6-8-69 11:50 AM. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. B. COUNTY Allegany | |
| FULL NAME OF HOSPITAL OR INSTITUTION
38 University Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Cumberland D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
703 Geppert Dr. | | | | | |
| 5. SEX M | 6. RACE Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-11-27 | 9. AGE (in years last birthday) 41 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
laborer | | 10B. KIND OF BUSINESS OR INDUSTRY
Tire Co. | | 11. BIRTHPLACE (State or foreign country)
Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
John McKenney | | | |
| 14. MOTHER'S MAIDEN NAME
Ruth N. Knippenburg | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
11/15/45 - 2/28/47 | | | |
| 16. SOCIAL SECURITY NO.
212-24-0072 | | 17. INFORMANT
Hosp. chart | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
201X I | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Respiratory arrest | | 12 hrs. | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF:
thrombosis to peria | | 12 hrs. 1 month | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF:
Hodgkin's Dis. | | 3 years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-30 19 69 to 6-8 19 69 that (I) (we) lost saw the deceased alive on 6-8 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
G. M. D., M.D. | | | | 23B. DATE SIGNED
6-8-69 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
Univ. Hosp. Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/11/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Restlawn Memorial Gardens | |
| 24D. LOCATION (City, town, or county) (State)
Cumberland, Allegany Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | | |
| 25B. NAME OF REGISTRAR
James E. McKenney | | 25C. FUNERAL DIRECTOR
H. Wayne George | | | |
| ADDRESS
21502 | | | | | |



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RALPH JONES

2. DATE AND HOUR OF DEATH

JUNE 8, 1969 9:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE

BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2324 EAST BALTIMORE STREET 21224

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

6-6-11

9. AGE (In years)

38

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

TEXAS

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES JONES

14. MOTHER'S MAIDEN NAME

IDA EDITH WALKER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

7

17. INFORMANT

ADDRESS

BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Respiratory Arrest

Min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Chronic Obstructive Pulmonary Disease

(C) DUE TO, OR AS A CONSEQUENCE OF:

Trauma

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Tuberculosis - inactive

Decade

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/4 19 69 to 6/8 19 69, that (I) (we) last saw the deceased alive on 6/8 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph Kaplan

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

6/8/69

23C. PHYSICIAN'S NAME (Type)

JOSEPH KAPLAN

23D. ADDRESS

BALTIMORE CITY HOSPITALS
4940 EASTERN AVE. BALTO. MD. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-11-1969

24C. NAME OF CEMETERY OR CREMATORY

Fairview Cemetery

24D. LOCATION (City, town, or county) (State)

Hubbard, Texas

25A. DATE REC'D BY HEALTH DEPT.

JUN 12 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Wm. Brooks Brooks Tolson 1050 York Rd. 21204

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

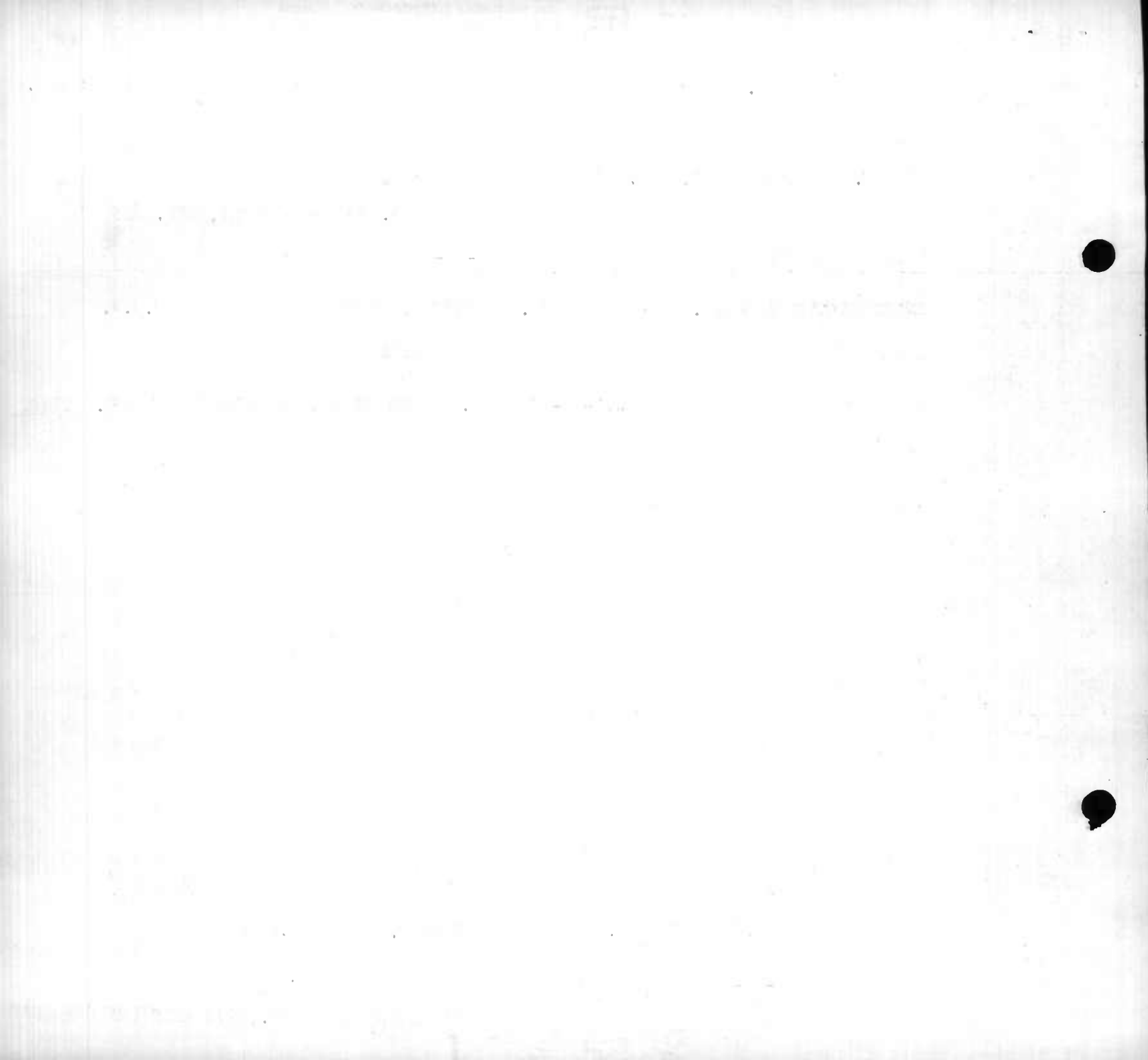


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. F-260 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5950 | |
|---|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) DAVID F. FISHER | | | | 2. DATE AND HOUR OF DEATH
JUNE 8, 1969 11:30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

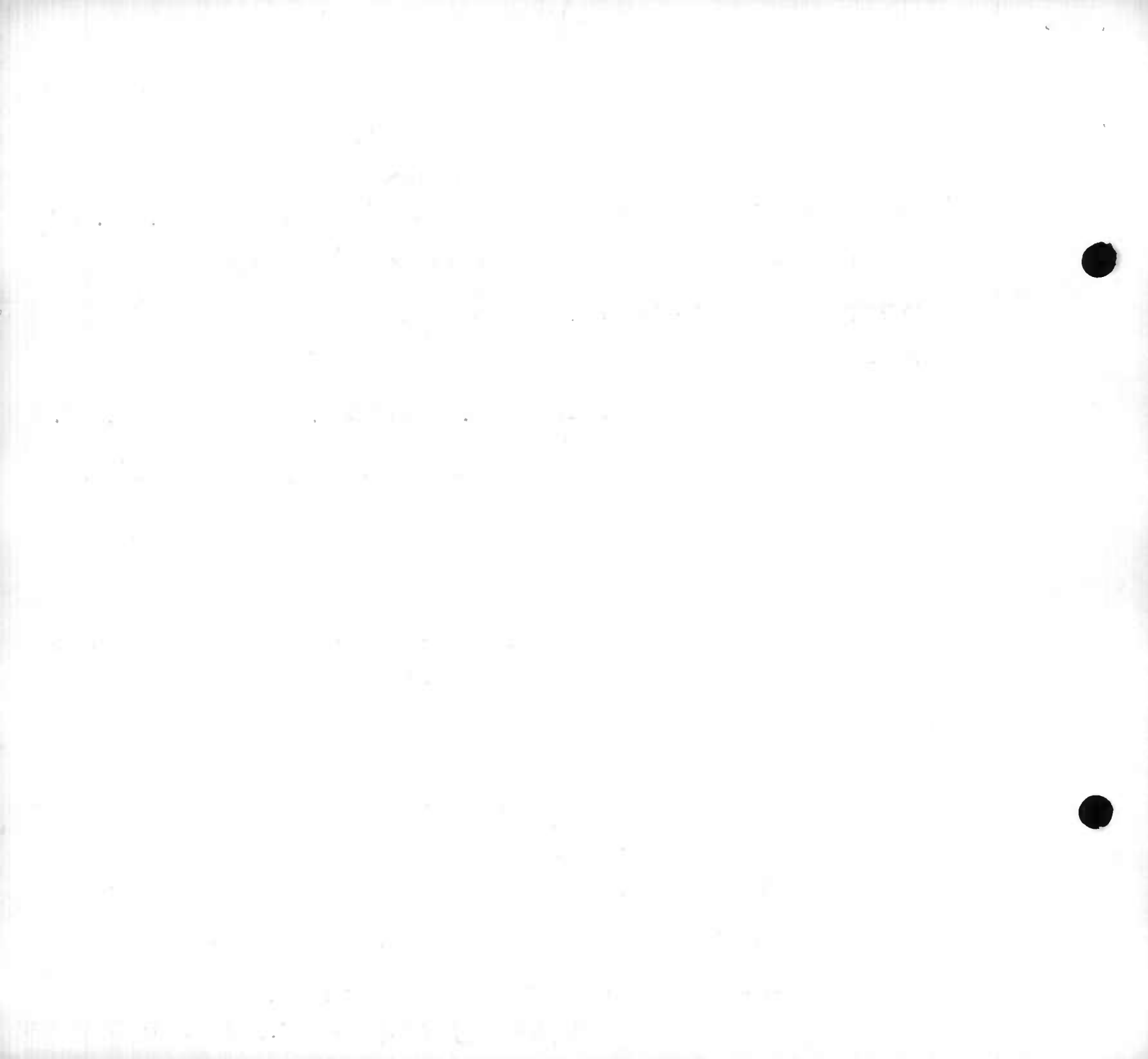
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
3900 N. CHARLES STREET, APT. 305 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 12-01 | | | |
| 5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 8. DATE OF BIRTH 2-14-04 9. AGE (In years last birthday) 65 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KRISHER SALES REP. | |
| 11. BIRTHPLACE (State or foreign country) NORFOLK, VIRGINIA | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME LOUIS FISHER | | | | 14. MOTHER'S MAIDEN NAME MOLLIE ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 212-09-0127A | | 17. INFORMANT ADDRESS MR. JEROME PIVEN, 500 EQUITABLE BLDG. #21202 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
162.1 I
CAUSE OF DEATH
carcinoma of lung
6 months | | | | 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22A. AUTOPSY? (Yes or No) | | 22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 5, 1969 to June 8, 1969 , that (I) (we) last saw the deceased alive on June 8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Samuel Whitehouse M.D. | | | | 23B. DATE SIGNED June 9/69 | | | |
| 23C. PHYSICIAN'S NAME (Type) SAMUEL WHITEHOUSE | | | | 23D. ADDRESS 3900 N. CHARLES STREET | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 6-10-69 | | 24C. NAME of CEMETERY or CREMATORY CHIZUK AMUNO | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR 256 E. Fisher, R.D. | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> L-500 69 5951 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 69 5951 </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Leon Lamm | | 2. DATE AND HOUR OF DEATH
June 9, 1969 18 30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. B. COUNTY Baltimore Co. | | 5. CITY OR TOWN Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Sinai Hospital of Baltimore | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 8/6/98 | | 9. AGE (In years last birthday) 70 | | 10. AGE (In years last birthday) 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY
JEWELRY STORE | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
CHARLES LAMM | | 14. MOTHER'S MAIDEN NAME
SARAH ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
216-05-5422 | | 17. INFORMANT
MRS. FRANCES LAMM, 6908 MARSUE DRIVE, APT. 1 D | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
410.91 | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE G-I hemorrhage
DUE TO, OR AS A CONSEQUENCE OF:
(B) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF:
(C) chronic renal disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
9 days
10 years | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
II | | 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
NO | |
| 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (he) (this hospital) attended the deceased from May 31 19 69 to June 9 , 19 69 that (I) (we) last saw the deceased alive on June 9 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | |
| 23A. SIGNATURE
Barry Green, M.D. | | 23B. DATE SIGNED
6/9/69 | | 23C. PHYSICIAN'S NAME (Type)
Barry Green, M.D. | |
| 23D. ADDRESS
Sinai Hospital of Baltimore | | 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-10-69 | |
| 24C. NAME OF CEMETERY OR CREMATORY
ANSHE EMUNAH (AITZ CHAIM) | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | |
| 25B. NAME OF REGISTRAR
Barry E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
SOLO LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | 25D. ADDRESS
SOLO LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |

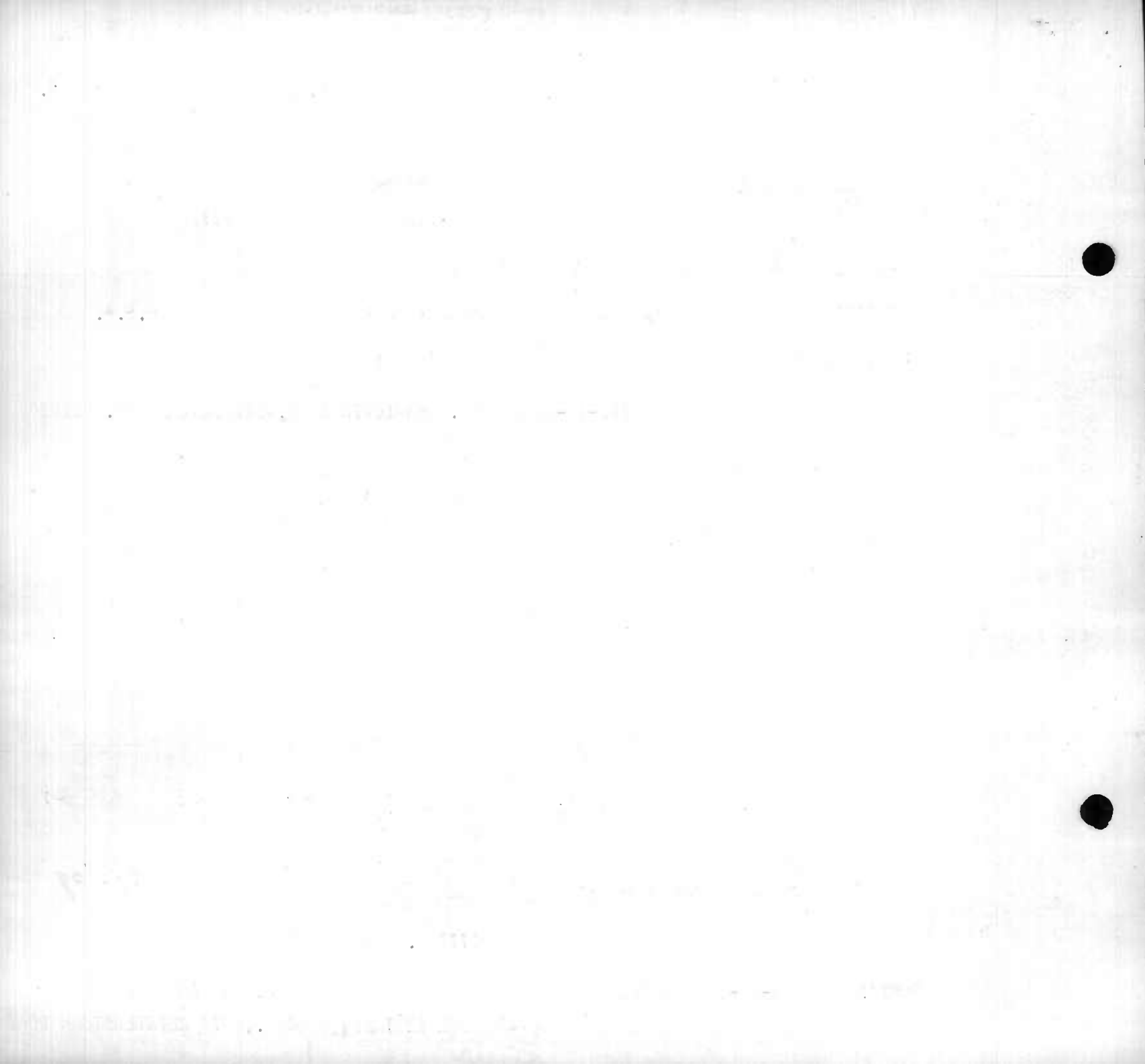


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

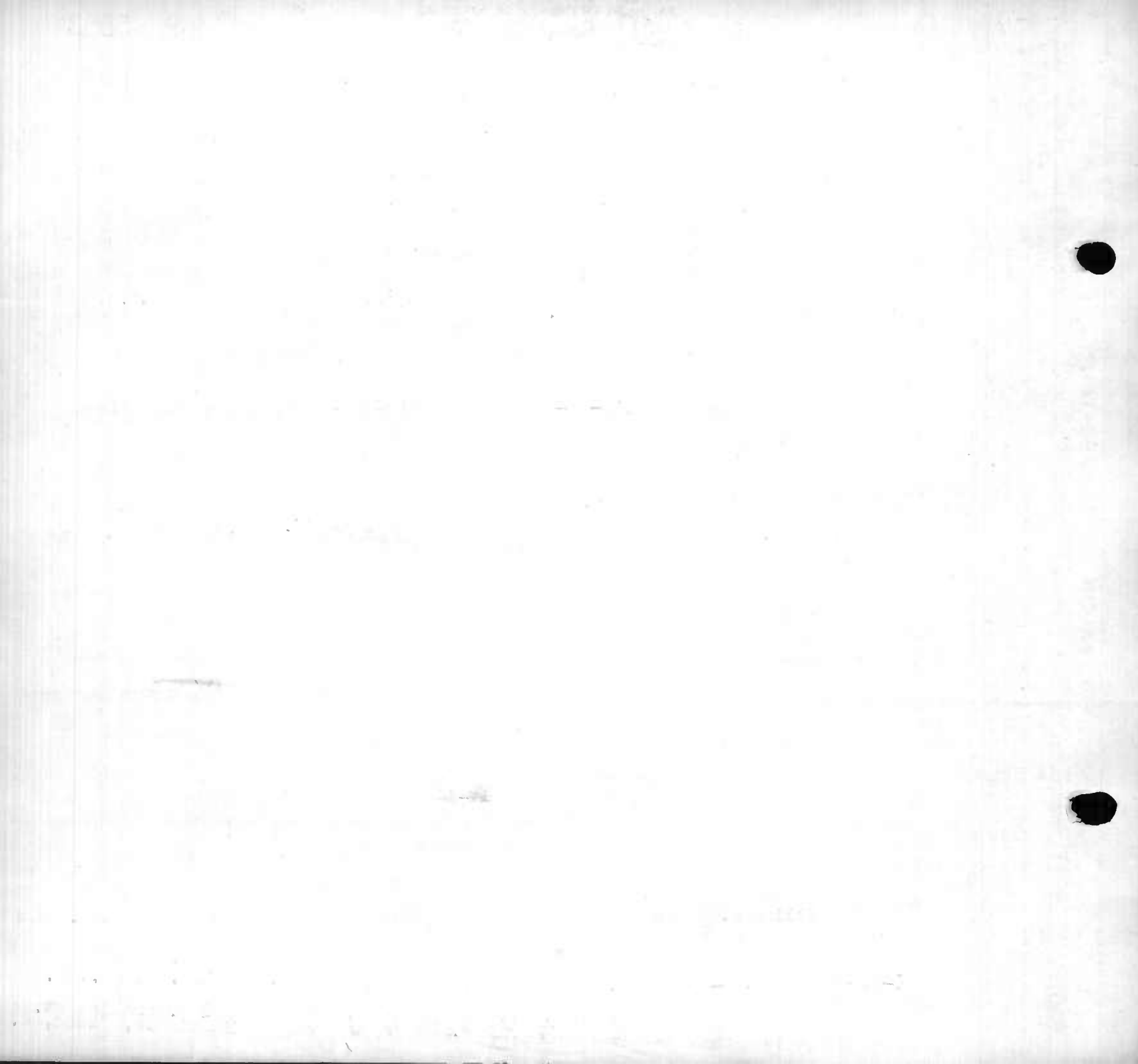
| L-100 69 5952 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5952 | |
|--|---|---|--|--|--|---|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) LOUIS LEVY | | | | 2. DATE AND HOUR OF DEATH
JUNE 8, 1969 6:15 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
ST AGNES HOSPITAL
40 | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 4512 DUNLAND ROAD #21229 | | | |
| 5. SEX
MALE | 6. RACE
WHITE
BLACK | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
XX 82 | | 9. AGE (In years last birthday)
88 82 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MERCHANT | | 10B. KIND OF BUSINESS OR INDUSTRY
RETAIL | | 11. BIRTHPLACE (State or foreign country)
ENGLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
BERNARD LEVY | | | | 14. MOTHER'S MAIDEN NAME
IDA ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
117-14-5189 | | 17. INFORMANT
MRS. CHARLOTTE LEVY, 4512 DUNLAND RD. #21229 | | | |
| 18. 412.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
Cerebro-Vascular Thrombosis
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerotic Cardio-Vascular Disease
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours
? | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
_____ | | | | | | | |
| 19A. DATE OF OPERATION
D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/17 1966 to 4/8 1969 , that (I) (we) last saw the deceased alive on 6/8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Joseph S. Blum | | | | 23B. DATE SIGNED
6/9/69 | | 23C. PHYSICIAN'S NAME (Type)
JOSEPH BLUM | |
| 23D. ADDRESS
1115 N. CALVERT STREET | | | | 23E. DEGREE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6-10-69 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE HEBREW | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
Robert E. Halber, M.D. | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. | | 25D. ADDRESS
6010 REISTERSTOWN ROAD | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|---|--|--|---|--|--|
| M-530 | | 69 5953 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5953 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) MUNDT, FRANCES, F. | | | |
| 2. DATE AND HOUR OF DEATH
6/10/69 | | | | 7:45 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | C. CITY OR TOWN
Dundalk | | | |
| | | | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER
1323 Willow Road 21222 | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-29-1900 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months: <input type="checkbox"/> Days: <input type="checkbox"/> | If Under 24 Hrs. Hours: <input type="checkbox"/> Min: <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Work | | | 10B. KIND OF BUSINESS OR INDUSTRY
At Home. | | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
Joseph Kuhn | | | | |
| 14. MOTHER'S MAIDEN NAME
Josephine Kern | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO.
219-10-5406 | | | | | 17. INFORMANT
Records: BCH-4940 Eastern Avenue 21224 | | |
| 18. CAUSE OF DEATH
412.21
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vasc. Accident
(B) Hypertension Cardiac Cardio Vasc. Disease Years
(C) 2 weeks
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| MEDICAL CERTIFICATION
19A. DATE OF OPERATION
2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Yes
20A. AUTOPSY? (Yes or No)
Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11-24-1968 to 6/10-1969 , that (I) (we) last saw the deceased alive on 6/10-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.
23A. SIGNATURE
William W. Brockman MD
23B. DATE SIGNED
6/10/69
23C. PHYSICIAN'S NAME (Type)
William W. Brockman MD
23D. ADDRESS
4940 Eastern Avenue, Baltimore, Md. 21224
24A. BURIAL CREMATION, REMOVAL (Specify)
6-13-69
24B. DATE
6-13-69
24C. NAME OF CEMETERY or CREMATORY
Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State)
7225 Eastern Blvd., Ba. Co., Md.
25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969
25B. NAME OF REGISTRAR
Charles J. Zeller
25C. FUNERAL DIRECTOR
901 S. Conkling St. Baltimore, 21224, Md. | | | | | | | |



1
B-230

69 5954 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 5954 REG. NO.

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) JAMES Royal BUCKHEIT | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year Hour
Estimated <input checked="" type="checkbox"/> June 10, 1969 2:40 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Mercy Hospital (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 10, 1969 2:40 A.M. | |
| 6. SEX
male | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE
white | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
July 13-1944 | | 10. AGE (In years last birthday)
24 | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ACCOUNTANT | | 15. MOTHER'S MAIDEN NAME
Thelma Condon | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
yes 5/18/62 - 5/17/65 | | 17. SOCIAL SECURITY NO.
315-40-5000 | |
| 18. INFORMANT
Mrs Thelma Wyatt | | ADDRESS
4416 Parkton St. | |
| 19. CAUSE OF DEATH
E953X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Asphyxia by Ligature
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION
6/13/69 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
<input checked="" type="checkbox"/> | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
jail cell | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Cell #7, Central Police Station | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)
6/10/69 2:10 A.M. | |
| 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Subj. hung himself in jail | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
6/10/69 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
6/13/69 | | 24B. DATE
6/13/69 | |
| 24C. NAME of CEMETERY or CREMATORY
BALTO NATL CEM. | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
George A. Schwab Inc | | ADDRESS
BALTO. | |

10/13/69 - Birth certificate of deceased.
G-05295. *Acc.*

G-05296

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5955

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LILA JONES

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

June 4, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 4, 1969

9:44 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Harford Co.

62-00

C. CITY OR TOWN

Joppa

D. INSIDE CITY LIMITS?

YES ☐NO ☐

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

X NOV 17 1917

10. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1611 Manchester Road

11. BIRTHPLACE (State or foreign country)

MAYSVILLE SC

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

ISSAC WELL

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

X HENRETTA WELLS LOWERY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

X 218-326918

18. INFORMANT

Alphens Jones

ADDRESS

Joppa MD

19.

412.2

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Hypertensive cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE *Charles S. Springate* M.D.EXAMINER'S
NAME (Type) Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 5, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-9-69

24C. NAME of CEMETERY or CREMATORY

Community Baptist

24D. LOCATION

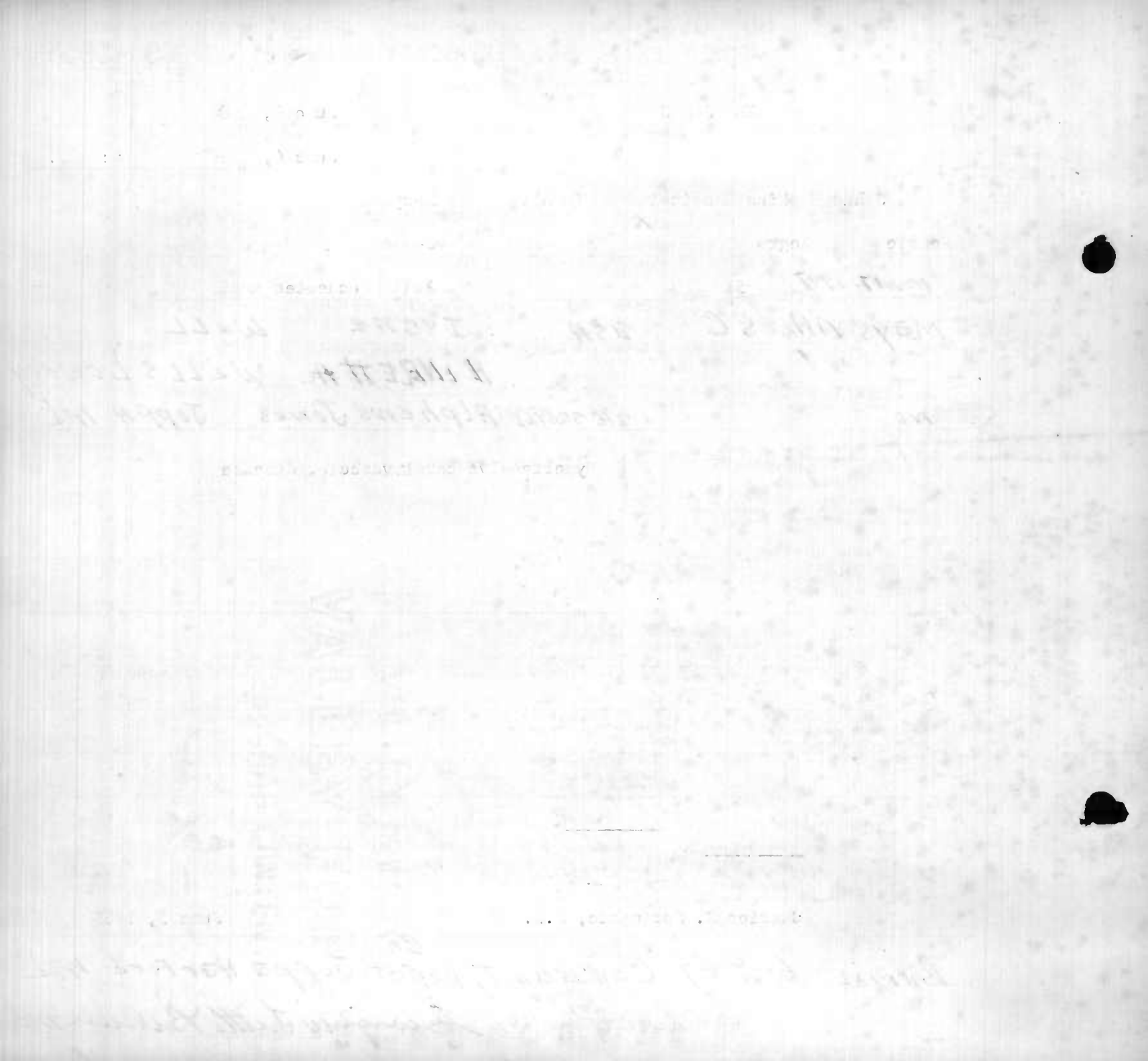
Joppa Harford MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

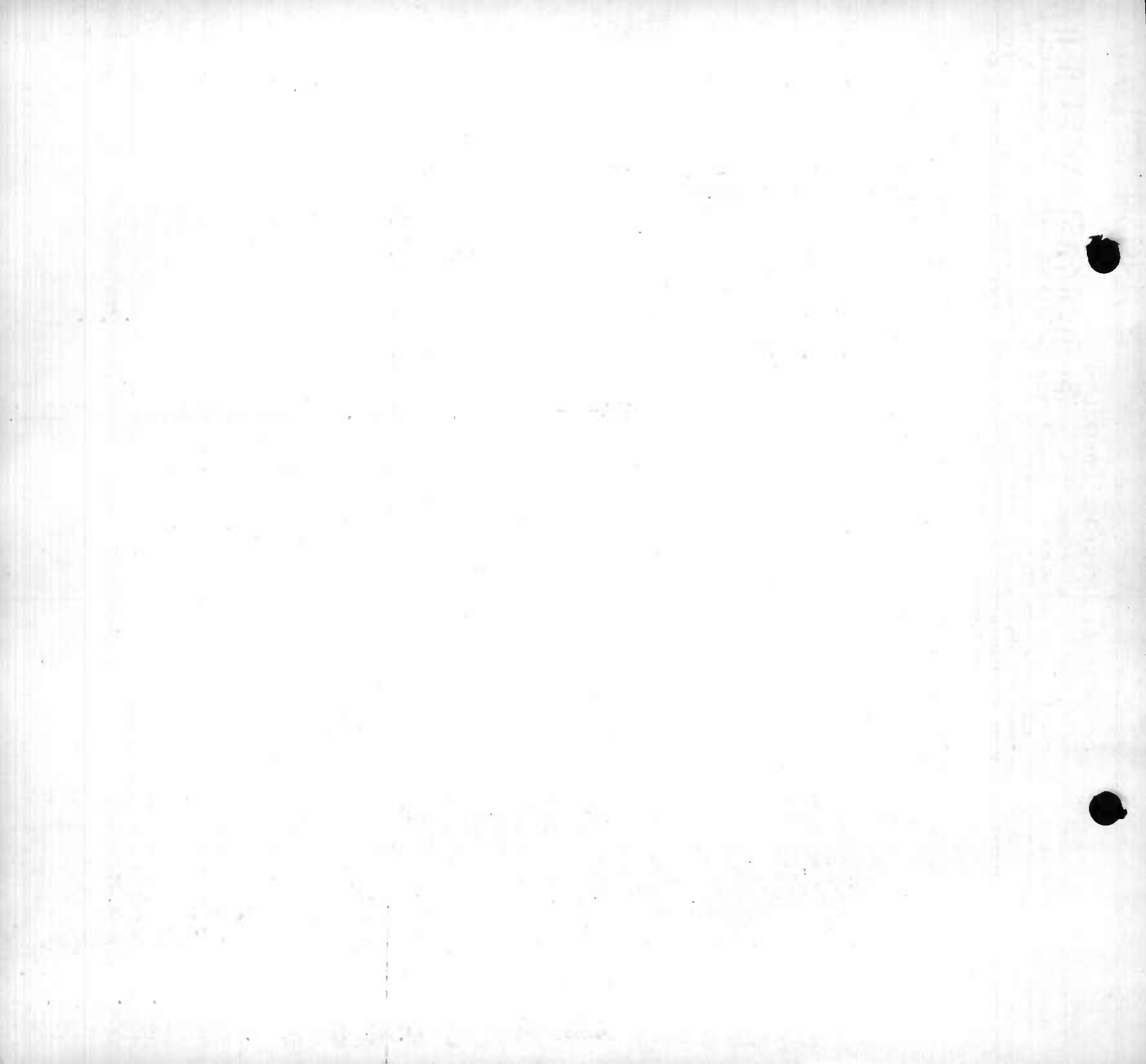
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|---|---|---|--|--|---|--|--|
| 69 5956 CERTIFICATE OF DEATH | | | | | REG. NO. 69 5956 | | | | |
| BIRTH NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) LITTLE, JESSIE | | | | | 2. DATE AND HOUR OF DEATH
6/8/69 12:35 P. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
HOUSE IN THE PINES - BELVEDERE NURSING AND CONVALESCENT HOME | | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | E. STREET AND NUMBER
6115 Windsor Mill Road | | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1/14/1900 | | 9. AGE (In years last birthday)
69 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Insurance | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Riggs, Warfield | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Edmund J. Little | | | | 14. MOTHER'S MAIDEN NAME
Mary Henthorn | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes WW 2 | | | | 16. SOCIAL SECURITY NO.
212-01-6074 | | 17. INFORMANT
Mrs. Ethel M. Little 6415 Windsor Mill Rd. | | | |
| 18. 1777 I | | | | | CAUSE OF DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
CARDIOVASCULAR collapse
(B) Metastatic Carcinoma of the
DUE TO, OR AS A CONSEQUENCE OF:
LIVER metastases + Cachexia
(C) | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
6/6/69 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
6 | | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 6/1/69 19 69 to 6/8 19 69 , that (2) (we) last saw the deceased alive on 6/8/69 and that in (my) (our) opinion death occurred on the date 6/8/69 and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Elliot Mankowitz M.D. | | | | | 23B. DATE SIGNED
6/8/69 | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS
112 E. Church St. Hills Road | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/11/69 | | 24C. NAME OF CEMETERY or CREMATORY
Druid Ridge | | | 24D. LOCATION (City, town, or county) (State)
Pikesville Balto. Co. Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | | 25B. NAME OF REGISTRAR
John T. Sandbury, Sr. | | | 25C. FUNERAL DIRECTOR ADDRESS
6411 Windsor Mill Rd. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

REG. NO. 69 5957

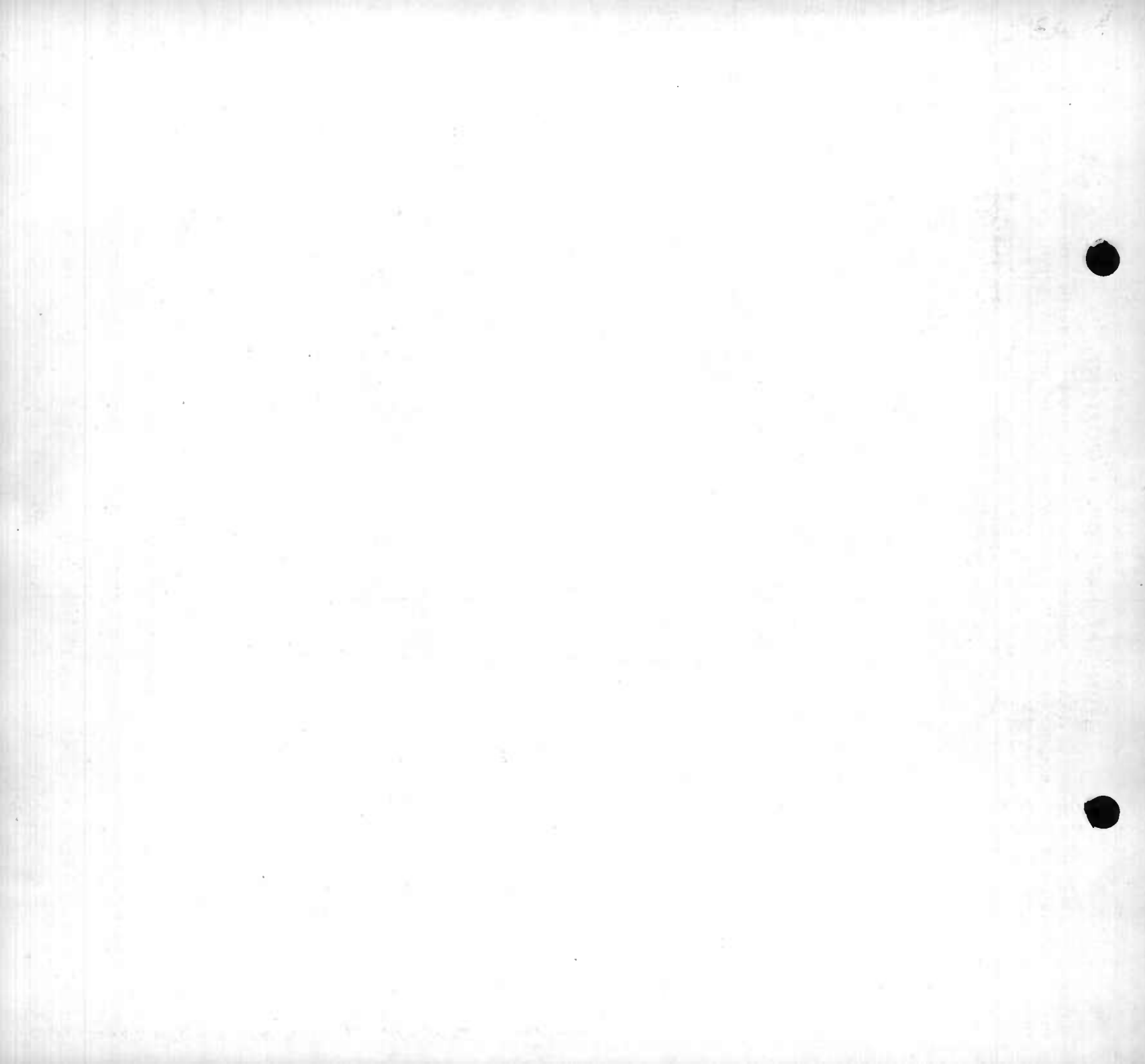
| | | | |
|---|------------------|--|--|
| BIRTH NO. 69-10685 | | REG. NO. 69 5957 | |
| 1. NAME OF DECEASED
(Type or Print) HEMP, BABY BOY | | 2. DATE AND HOUR OF DEATH
JUNE 5, 1969 12:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
40 ST. AGNES HOSPITAL
CATON & WILKENS AVES.
BALTIMORE, MARYLAND 21229 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE & COUNTY
MARYLAND ANNE ARUNDEL CO 21061
C. CITY OR TOWN
GLEN BURNIE
D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER
1618 PLEASANTVILLE DR. 52-00 | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
06 05 69 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
1 58
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CLAYTON HEMP | | 14. MOTHER'S MAIDEN NAME
BETTY (KIRBY) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
AVES. BALTIMORE, MD. 21229
ST. AGNES HOSP RECORDS-CATON & WILKENS | | ADDRESS | |
| 18. CAUSE OF DEATH
I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
IMMEDIATE CAUSE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Immaturity
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. HOW DID INJURY OCCUR? | |
| 21E. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21F. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 22. I certify that (X) (this hospital) attended the deceased from JUNE 5 19 69 to JUNE 5 19 69 that (IX) (we) last saw the deceased alive on JUNE 5 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
S. Aziz, M.D. | | 23B. DATE SIGNED
6-9-69 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
CATON & WILKENS AVES.-BALTO MD. 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/11/69 | |
| 24C. NAME OF CEMETERY OR CREMATORY
Lorraine Cemetery | | 24D. LOCATION (City, town, or county)
Balto Co Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
Robert E. Sabers, M.D. | |
| 25C. FUNERAL DIRECTOR
Mrs. Collette H. V37 | | 25D. ADDRESS
Salisbury Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5958 | |
|---|---------------------|---|-----------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) MEAD PELHAM | | 2. DATE AND HOUR OF DEATH
6/9/69 4:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE | | 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
CHURCH HOME & HOSPITAL | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER
3500 LOUTH RD. (LV) | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/7/98 | 9. AGE (In years last birthday)
70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Restaurant Manager | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
N.Y. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
KENNETH MEAD (D) | | 14. MOTHER'S MAIDEN NAME
MARY KOEGER (D) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT DELHAM K MEAD ADDRESS
105 SEAMAN AVE. FREEPORT NY-11520 | |
| 18. 519.21
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
RESPIRATORY FAILURE | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Chronic Obstructive pulm. disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) _____ | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-29 19 69 to 6-9- 19 69 , that (I) (we) lost saw the deceased alive on 6-9- 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Jose F. Mier, Jr. M.D. | | 23B. DATE SIGNED
6-9-69 | | 23C. PHYSICIAN'S NAME (Type)
Jose F. Mier, Jr. M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6/12/69 | | 24C. NAME OF CEMETERY OR CREMATORY
OAK LAWN CEMETERY | |
| 24D. LOCATION
COLGATE MD | | 24E. ADDRESS
100 N. Broadway BALT. MD. 21231 | | 24F. (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
Wm E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
ELLERKA FUNERAL HOME - DUNDALK MD | |
| 25D. ADDRESS | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

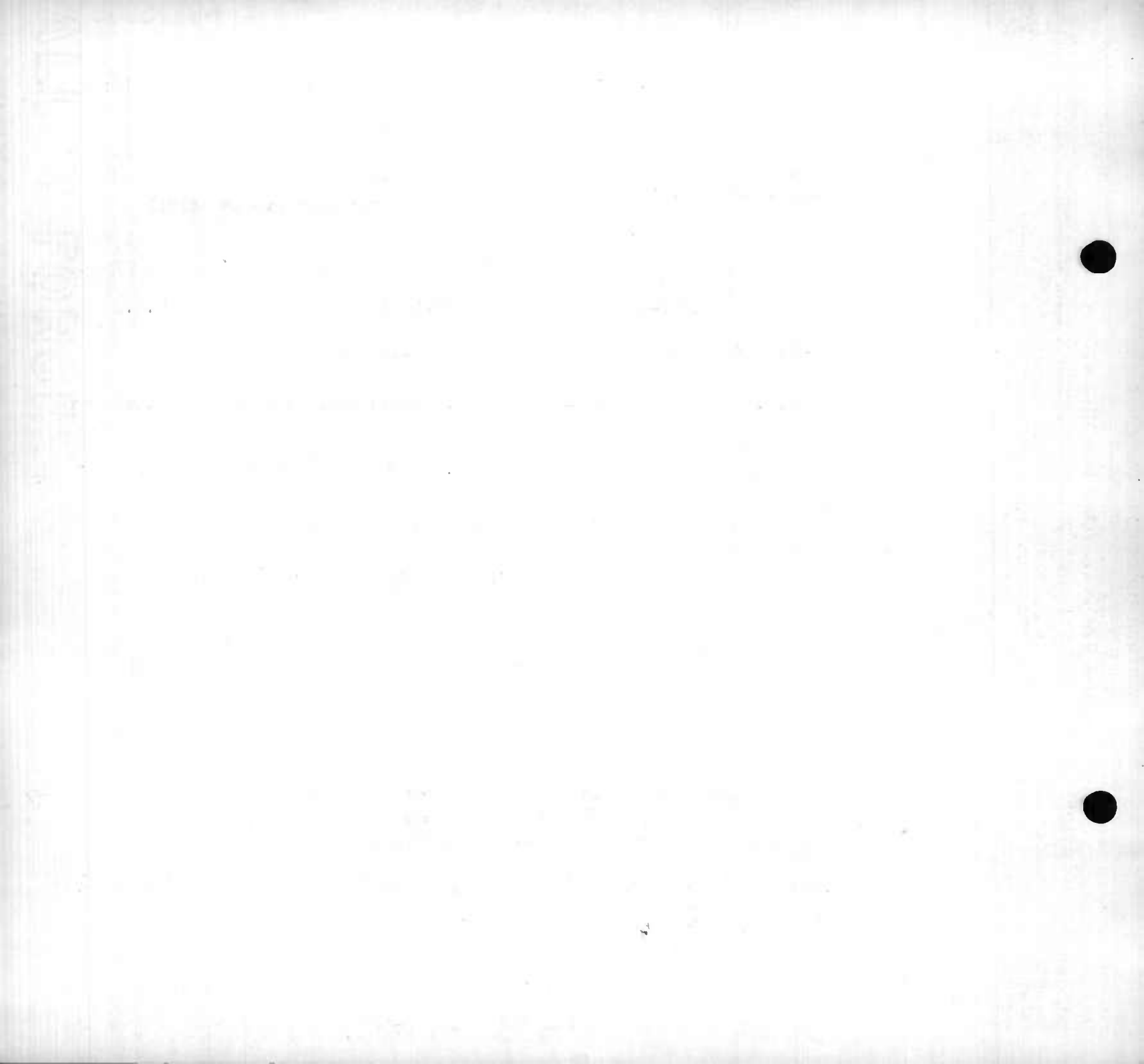
69 5959

CERTIFICATE OF DEATH

REG. NO. 69 5959

| | | | | | |
|---|------------------|---|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Audley G. Bennett | | Jun 9, 1969 10:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

00 | | | A. STATE Maryland
B. COUNTY 13-06 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
3365 Chestnut Avenue
Baltimore, Md. 21211 | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
3365 Chestnut Avenue 21211 | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 2, 1894 | 9. AGE (In years last birthday)
76 yrs. | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | 10B. KIND OF BUSINESS OR INDUSTRY
Self-employed | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | 13. FATHER'S NAME
Nelson Bennett | | 14. MOTHER'S MAIDEN NAME
Alice Moore | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes W.W. I | | 16. SOCIAL SECURITY NO.
577-16-2914 | | 17. INFORMANT ADDRESS
Mrs. Beulah Bennett - 3365 Chestnut Ave | |
| 18. CAUSE OF DEATH
I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
sudden | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Coronary Thrombosis | | | | | |
| (B) Generalized atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) Chronic Artery obstruction
DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-10 19 65 to 6-9 19 69, that (I) (we) lost saw the deceased alive on 6-11 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Reuben Hoffman, M.D. | | | | 23B. DATE SIGNED
8-11-69 | |
| 23C. PHYSICIAN'S NAME (Type)
REUBEN HOFFMAN, M.D. | | | | 23D. ADDRESS
846 W. 76 St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Nat'l Cemetery | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. NAME OF CEMETERY or CREMATORY | | 24F. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
E. E. E. E. | | 25C. FUNERAL DIRECTOR ADDRESS
Frank N. Seitz 814 W 36 St. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5960

| | | | | | |
|---|---------------------|---|------------------------------------|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) ROSA BUTLER | | 2. DATE AND HOUR OF DEATH
6/9-69 11:40 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 14-03 | | C. CITY OR TOWN Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Maryland General Hospital | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
1802 Eutaw | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-20-23 | 9. AGE (In years last birthday)
86 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sewing Machine Operator | | 10B. KIND OF BUSINESS OR INDUSTRY
Goodwill Ind. | | 11. BIRTHPLACE (State or foreign country)
Baltimore | |
| 13. FATHER'S NAME
Rost | | 14. MOTHER'S MAIDEN NAME
Kate | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-18-2368 | | 17. INFORMANT
Mrs. Thelma Martin ADDRESS 3007 Chestnut Ave. | |
| 18. CAUSE OF DEATH
412.4 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (A) IMMEDIATE CAUSE Dehydration
DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (B) Chronic Brain Syndrome
DUE TO, OR AS A CONSEQUENCE OF: | | (C) ASCVD | | | |
| 19A. DATE OF OPERATION
6-9-69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-6-69 to 6-9-69 that (I) (we) last saw the deceased alive on 6-9-69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Donald W. Bryan M.D. | | 23B. DATE SIGNED
6-9-69 | | 23C. PHYSICIAN'S NAME (Type)
Jim McPhillips M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-12-69 | | 24C. NAME OF CEMETERY OR CREMATORY
Parkwood Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Parkwood, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
James E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
George H. Searcy | | 25D. ADDRESS
814 W 36 St. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 5961

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS N. BLAND, Sr.

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

June 10, 1969

3:30 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 10, 1969

3:30 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

BALTIMORE

C. CITY OR TOWN

DUNDALK

D. INSIDE CITY LIMITS?

YES ☐NO ☒

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

MAY 6, 1903

10. AGE (In years
last birthday)

66

If Under 1 Yr. II Under 24 Hrs.

Months, Days, Hours, Min.

E. STREET AND NUMBER

21 Sunship Road

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM U. BLAND

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SUPERVISOR

14B. KIND OF BUSINESS OR INDUSTRY

FED. GOV.

15. MOTHER'S MAIDEN NAME

MARTHA A. RAMKEY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

223/14/1741

18. INFORMANT

FRANCES M. BLAND, WIFE,

ADDRESS SAME

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

19.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/11/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

13 JUNE, 69

24C. NAME OF CEMETERY OR CREMATORY

OAK LAWN

24D. LOCATION (City, town, or county)

BALTO. CO., MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

W. BROOKS BRADLEY, DUNDALK, MD.

10/1/1

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5962 CERTIFICATE OF DEATH

REG. NO. 69 5962

| | | | | | |
|--|-------------------------|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Margaret E. Yeager</i> | | 2. DATE AND HOUR OF DEATH
<i>6/10/69 7:30 AM</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

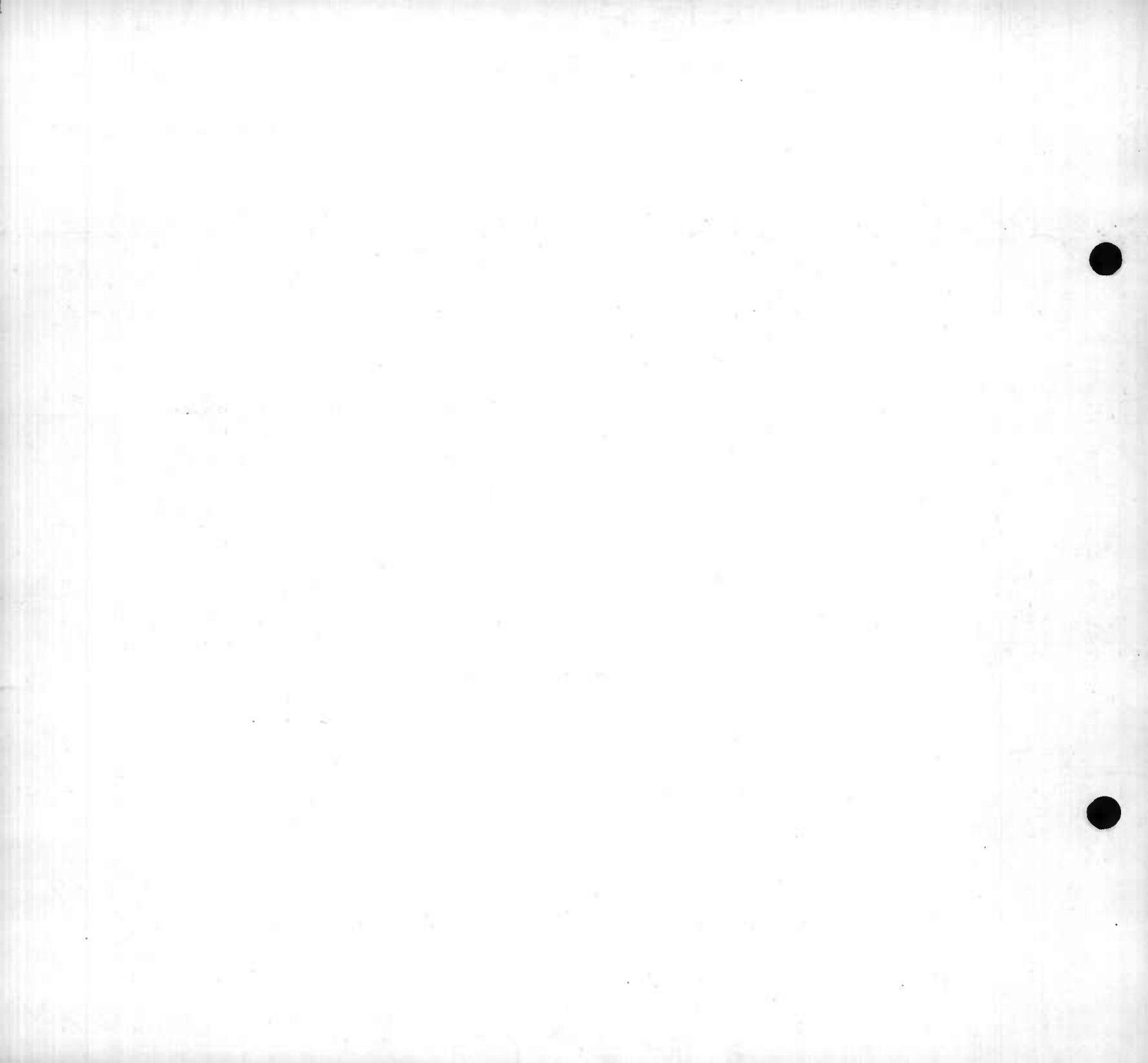
FULL NAME OF HOSPITAL OR INSTITUTION
<i>90 GOULD NURSING HOME</i>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <i>MD</i> B. COUNTY <i>BALTIMORE</i>
C. CITY OR TOWN <i>DUNDALK</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <i>1902 TYLER Rd.</i> | |
| 5. SEX
<i>FEM.</i> | 6. RACE
<i>WHITE</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>2/25/1888</i> | 9. AGE (In years last birthday)
<i>81</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>HOUSEWIFE</i> | | | 11. BIRTHPLACE (State or foreign country)
<i>PENNA.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> |
| 13. FATHER'S NAME
<i>? HELM</i> | | | 14. MOTHER'S MAIDEN NAME
<i>?</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | 16. SOCIAL SECURITY NO.
<i>313-07-34678</i> | 17. INFORMANT
<i>MRS. RUSSELL A. FETTERMAN</i> | | ADDRESS <i>AS ABOVE</i> |
| 18. <i>440.91</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<i>Arteriosclerosis, generalized</i>
<i>Rheumatoid Arthritis</i> | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<i>Rheumatoid Arthritis</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 yrs</i> | |
| 19A. DATE OF OPERATION
<i>No</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>No</i> | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<i>No</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<i>No</i> | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
<i>No</i> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<i>No</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>June 4 1968</i> to <i>June 10 1969</i> , that (I) (we) last saw the deceased alive on <i>6/4/1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>J. Sadaramanda M.D.</i> | | | | 23B. DATE SIGNED
<i>6/10/69</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>V. S. ADARAYANDA</i> | | 23D. ADDRESS
<i>6801 Belair Rd Balto 6 Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>6/11/69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>oak lawn</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>BALTO. CO., MD</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUN 12 1969</i> | | 25B. NAME OF REGISTRAR
<i>James E. J. Ben...</i> | | 25C. FUNERAL DIRECTOR
<i>George Bradley</i> | |
| | | | | ADDRESS
<i>Reverend, Md.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 5963

| | | | | | |
|--|---------------------|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>BERTHA KATZ</u> | | 2. DATE AND HOUR OF DEATH
<u>6.10.69</u> <u>7:30 A</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
<u>42 Sinai Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>15-10</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>42 Sinai Hospital</u> | | | | C. CITY OR TOWN <u>BALTIMORE</u>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
<u>OAKFORD AVE. 4010</u> <u>21215</u> | | | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>12/31/79</u> | 9. AGE (in years last birthday)
<u>89</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>HUNGARY</u> | |
| 13. FATHER'S NAME
<u>Morris</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Rex Katz</u> <u>6251 Pimlico Rd</u> | |
| 18. <u>250.91</u> CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>CHRONIC HEART FAILURE</u>
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>CHRONIC HEART FAILURE</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
<u>6.9.69</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>GANGRENE TOE</u> | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5-28-69</u> 19 to <u>6-10-69</u> 19 that (I) (we) last saw the deceased alive on <u>6-9-69</u> 19 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>J.R. Chloca</u> <u>interne</u>
DEGREE | | | | 23B. DATE SIGNED
<u>6.10.69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>I.R. Chloca</u> <u>interne</u>
DEGREE | | | | 23D. ADDRESS
<u>Sinai Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>6/11/69</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Tenthford Road</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Balto</u> <u>MD</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 12 1969</u> | | | |
| 25B. NAME OF REGISTRAR
<u>W.E. Taylor, R.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Sylvester S. Lewis & Son</u> <u>9610 Reisterstown Rd</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 5964 CERTIFICATE OF DEATH

REG. NO. 69 5964

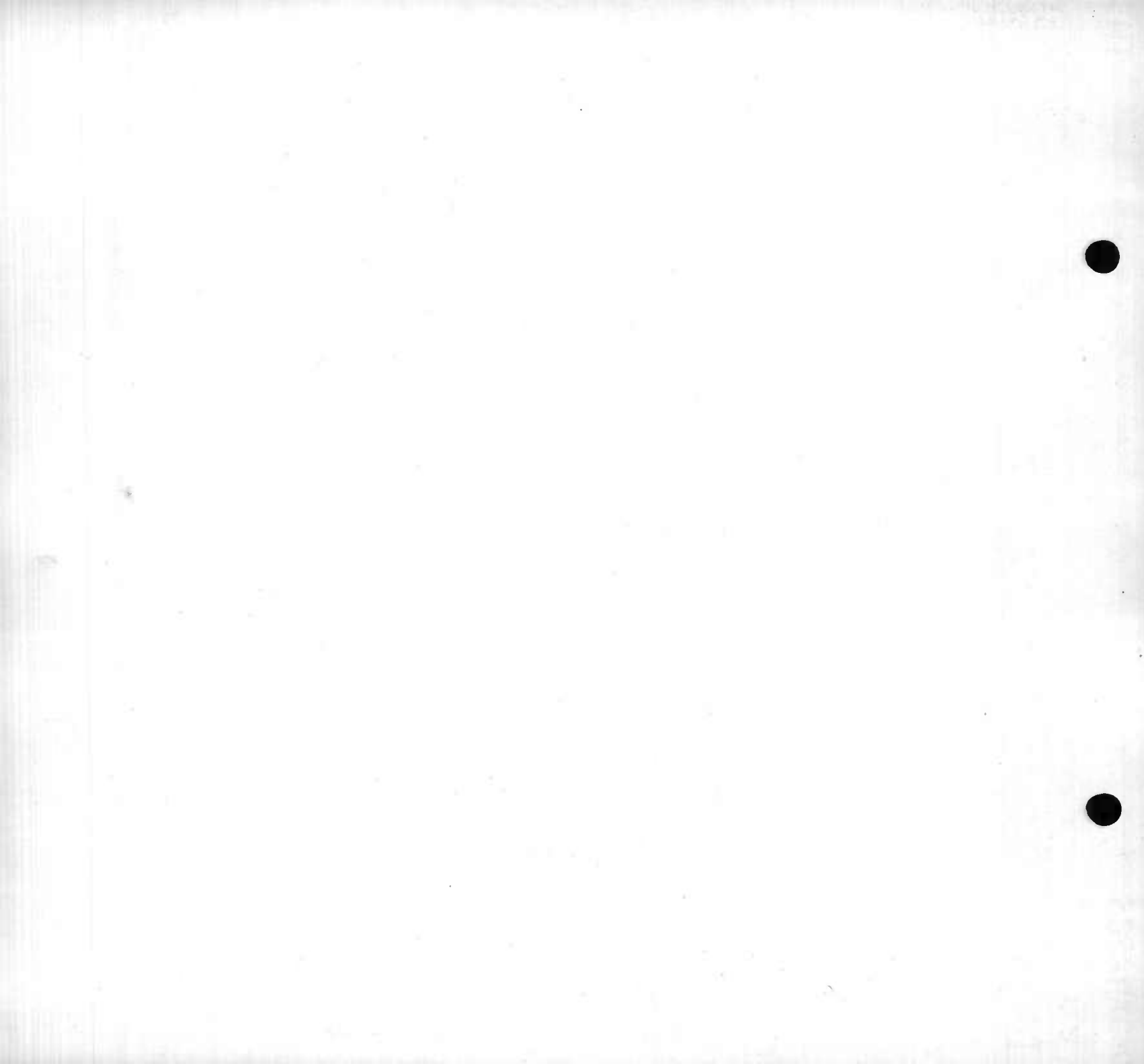
| | | | | | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) COOK, WILLIAM EDGAR | | 2. DATE AND HOUR OF DEATH
11 JUNE 1969 1 6:00 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 13-02 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SOUTH BALTIMORE GENERAL HOSPITAL
43 | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
1646 S. CHARLES ST. | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11 FEB 1893 | 9. AGE (In years last birthday)
76 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Firefighter | | 10B. KIND OF BUSINESS OR INDUSTRY
13 E F L | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | 13. FATHER'S NAME
COOK, WILLIAM E. | | |
| 14. MOTHER'S MAIDEN NAME
MARY GLEASON | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
Family - Same | | |
| 18. 150 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
CARCINOMA OF ESOPHAGUS
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
>18 MONTHS | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3 JUNE 1969 to 11 JUNE 1969 that (I) (we) last saw the deceased alive on 11 JUNE 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Barry A. Blum MD | | | | 23B. DATE SIGNED
11 JUNE 1969 | |
| 23C. PHYSICIAN'S NAME (Type)
BARRY ALAN BLUM MD | | | | 23D. ADDRESS
SOUTH BALTIMORE GENERAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
6/14/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Wm. Oliver | |
| 24D. LOCATION (City, Town, or county) (State)
Baltimore | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | | |
| 25B. NAME OF REGISTRAR
Wm. E. [unclear] | | 25C. FUNERAL DIRECTOR
130 E Toat Car | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

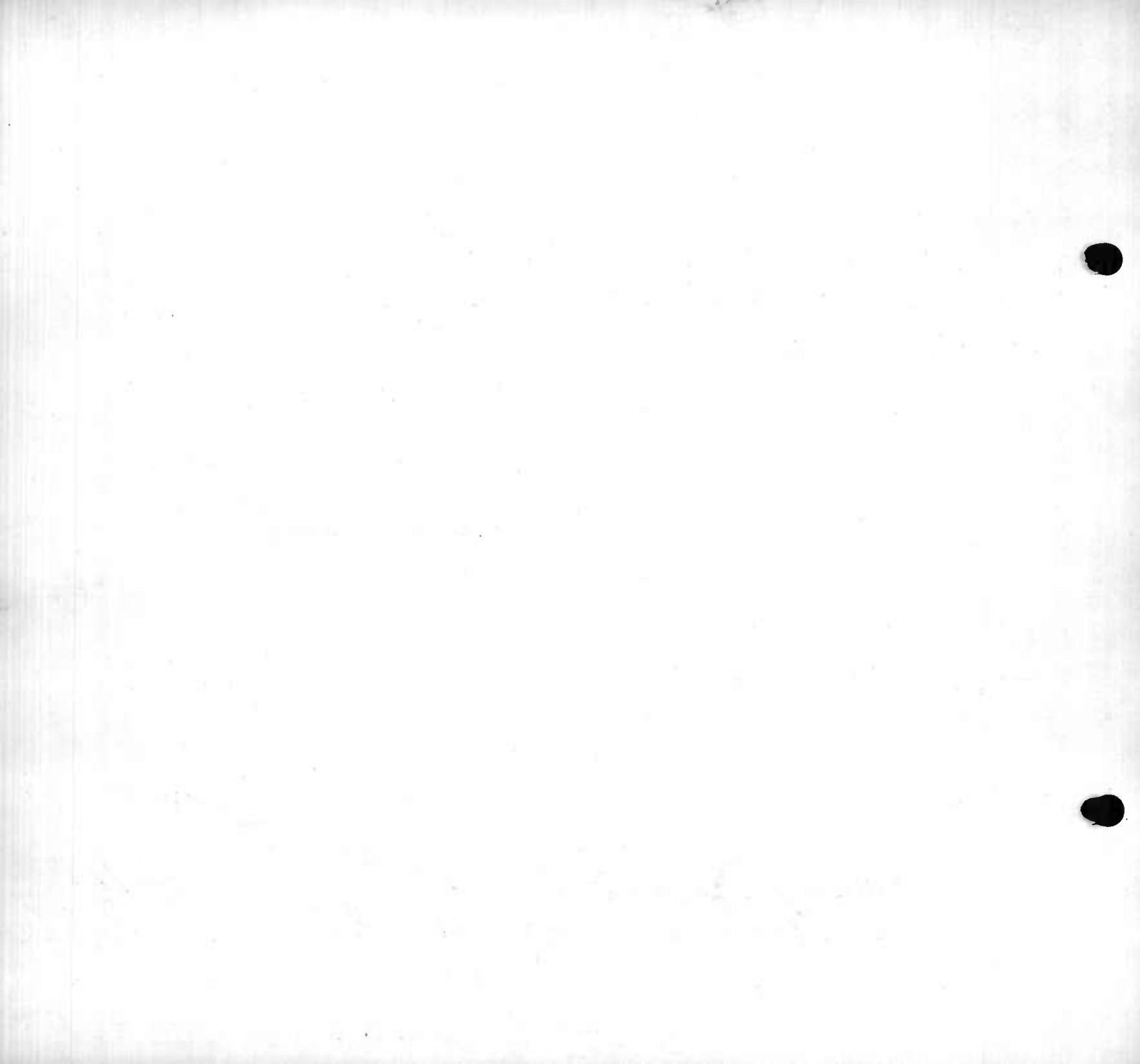
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|------------------|---|---------------------------------|---|--|
| BIRTH NO. | | 69 5965 | | 69 5965 | |
| 1. NAME OF DECEASED
(Type or Print) | | LILLIE E WICKS | | 2. DATE AND HOUR OF DEATH
June 11, 1969 4 ⁰⁰ A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE MD B. COUNTY | | 12-02 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 00 305 E. 33 rd ST. | | E. STREET AND NUMBER
305 E 33 rd ST. | | | |
| 5. SEX
F | 6. RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct 22-1884 | 9. AGE (In years last birthday)
84 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore | |
| 13. FATHER'S NAME
George Herr | | 14. MOTHER'S MAIDEN NAME
LOUISA MAINZ | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Miss D. WICKS | |
| 18. 440.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
INTERSCLEOTIC | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 15 1961 to June 11 1969, that (I) (we) last saw the deceased alive on June 10 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature] | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type)
[Signature] | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-13-69 | | 24C. NAME OF CEMETERY or CREMATORY
Western Cemetery | |
| 24D. LOCATION (City, town, or county)
Baltimore, Md | | 24E. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 24F. NAME OF REGISTRAR
J. E. PABLO, M.D. | |
| 24G. FUNERAL DIRECTOR
J. A. HARRIS | | 24H. ADDRESS
4200 Pennington Ave. | | 24I. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | REG. NO. 69 5966 |
|---|-------------------------|---|---|--|---|----------------------|
| BIRTH NO. 69 5966 | | | | | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) JOHN (JAN) ZAKOSCIELNY | | | 2. DATE AND HOUR OF DEATH
JUNE 8, 1969 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 1-04 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
3208 FOSTER AVE
00 | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | E. STREET AND NUMBER
812 S. MILTON AVE | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/3/1894 | 9. AGE (In years last birthday)
74 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
POLAND | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
SEBASTIAN | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
213-09-8194 | | 17. INFORMANT
MISS HELEN ZAKOSCIELNY | | |
| | | | | ADDRESS
812 S. MILTON AVE | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
185X I | | | CAUSE OF DEATH
Periphrigic Cardiac Collapse | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Coronaria Prorata | | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A) | | | | | | |
| 19A. DATE OF OPERATION
6/9/69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to June 8, 1969 , that (I) was lost saw the deceased alive on June 7, 1969 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 23A. SIGNATURE
Julius J. Janicki M.D. | | | | 23B. DATE SIGNED
6/9/69 | | |
| 23C. PHYSICIAN'S NAME (Type)
M. J. SAWORSKI M.D. | | | | 23D. ADDRESS
2711 Carter Ave Balto, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
6/9/69 | | 24C. NAME OF CEMETERY or CREMATORY
HOLY ROSARY CEMETERY | | |
| | | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE MD. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
John E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
REYNOLD D. KACZOROWSKI | | |
| | | | | ADDRESS
2525 FLEET ST. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|---|--|--|
| 69 5967 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5967 | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) SCHMIDT, MARY E. | | | 2. DATE AND HOUR OF DEATH
6/8/69 12:12A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

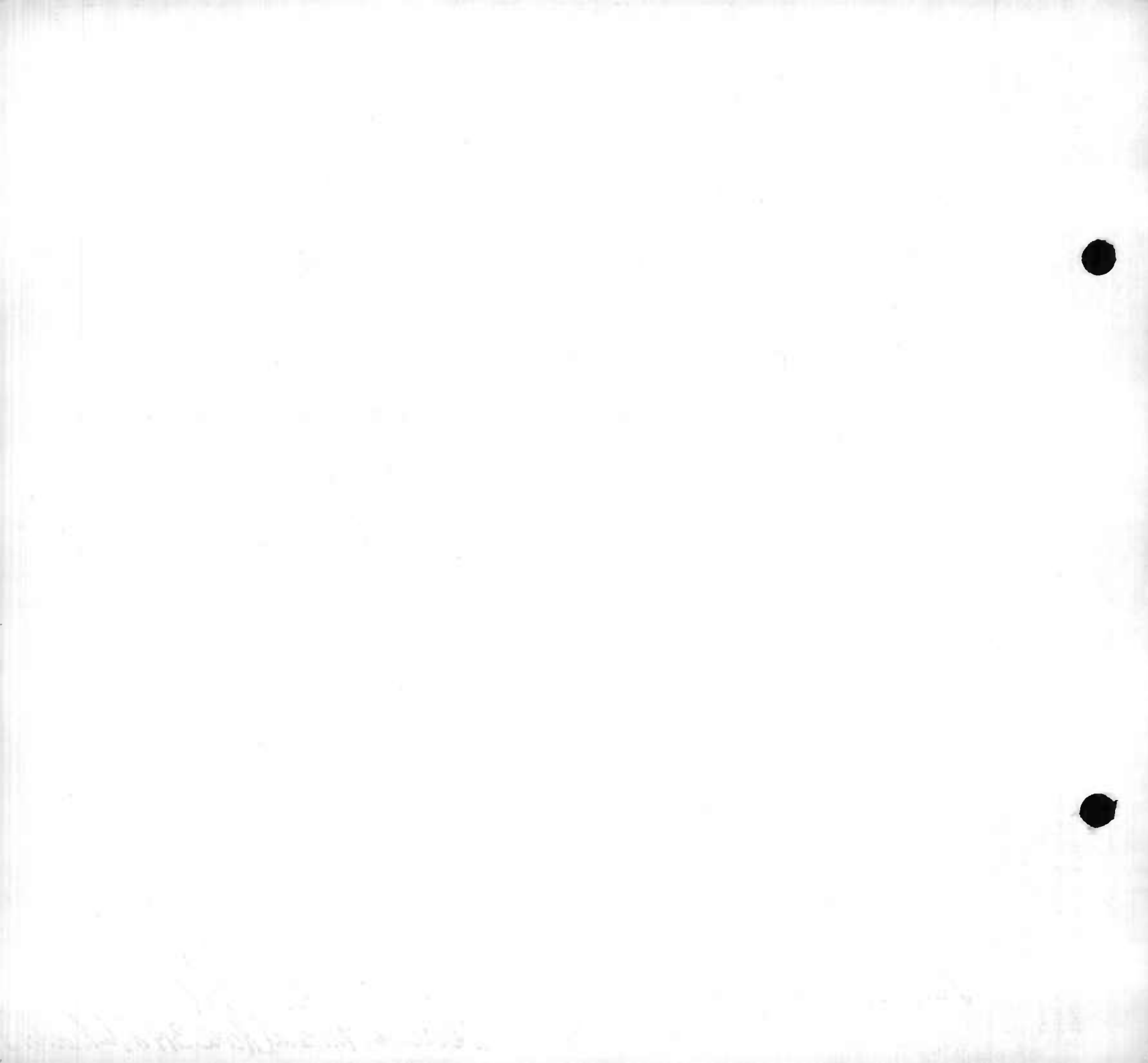
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
ST. AGNES HOSPITAL
CATON AND WILKENS AVE.
BALTO MD. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
BOX 129 HANOVER RD. Howard County
C. CITY OR TOWN HANOVER MD. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER BOX 129 HANOVER RD | | |
| 5. SEX
F. MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/13/05 | 9. AGE (In years last birthday)
63 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
B & O RAIL | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
John J. Connor | | | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
212-26-8566A | | 17. INFORMANT ADDRESS
Mr. Oscar Schmidt, Box 129 Hanover Road 21076 | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
6/7/69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
coronary heart disease | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 6/7/69 19 to 6/8/69 19 that (we) last saw the deceased alive on 6/8/69 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. Bruce Brumbaugh | | 23B. DATE SIGNED
6/9/69 | | 23C. PHYSICIAN'S NAME (Type)
Dr. Bruce Brumbaugh | |
| 23D. ADDRESS
5609 Main Street, Elkridge, Maryland | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | |
| 24B. DATE
6-11-69 | | 24C. NAME OF CEMETERY OR CREMATORY
Winfield Church of God Cemetery | | 24D. LOCATION (City, town, or county) (State)
Winfield Carroll Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
J. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 2122 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--------------|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | REG. NO. | | | |
| | | John Clement MALLICOTT | | 6/10/69 | | 12:01 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
University of Maryland Hospital | | | | A. STATE
MD BALTIMORE | | B. COUNTY | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER
12411 Poppleton St | | | | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7/24/00 | | 9. AGE (In years last birthday)
68 | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sanitor | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Robert Mallicott | | | | 14. MOTHER'S MAIDEN NAME
Cordelia Marshall | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
216-12-5257 | | 17. INFORMANT
James Mallicott | | | |
| | | | | ADDRESS
2509 Shirley Ave | | | | | |
| 18. 400.21
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Unicef Dismutation | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs | | | |
| | | | | (B) Intracerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF: | | 12 hrs | | | |
| | | | | (C) Malignant Hypertension | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nally medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/9 1969 to 6/10 1969 that (I) (we) last saw the deceased alive on 6/10 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Carol Lee Kooke | | | | 23B. DATE SIGNED
6/1/69 | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
CAROL LEE KOOKE | | | | 23D. ADDRESS
University Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
6/13/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt Auburn Cem Balto Md | | 24D. LOCATION
City, town, or county (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
Robert E. Jansen, M.D. | | 25C. FUNERAL DIRECTOR
McCrans Funeral Home | | ADDRESS
319 N. Calverton | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 25569</u> |
|--|--|---|---|---|
| BIRTH NO. <u>5-120</u> | | 69 5969 | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) <u>M. MAGGIE DAVIS</u> | | 2. DATE AND HOUR OF DEATH
<u>6/10/69</u> <u>1 10 30</u> A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>JOHNS HOPKINS HOSPITAL</u>
<u>33</u> | | A. STATE <u>Maryland</u>
B. COUNTY <u>13-02</u> | | |
| C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER
<u>2217 Linden Ave.</u> | | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/21/00</u> | 9. AGE (In years last birthday) <u>69</u>
If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | |
| 13. FATHER'S NAME
<u>Julius Smith</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Johnson</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Clarence Davis</u> same <u>husband</u> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>174 X1</u>
<u>2 METASTATIC BREAST CA</u>
<u>2M10</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>CHRONIC RENAL INSUFFICIENCY</u> | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/10/69</u> 19 to <u>6/10/69</u> 19 that (I) (we) last saw the deceased alive on <u>6/10/69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Jerome L. Rubin M.D.</u> | | 23B. DATE SIGNED
<u>6/10/69</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>JEROME RUBIN M.D.</u> | | 23D. ADDRESS
<u>JOHNS HOPKINS HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>6-14-69</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>St. Thomas Cemetery</u> | 24D. LOCATION (City, town, or county) (State)
<u>Randallstown Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR
<u>John E. Bailey, M.D.</u> | 25C. FUNERAL DIRECTOR V. <u>Kelson E. H.</u> ADDRESS
<u>1348 N. Calhoun Street</u> | | |

JUN 12 1969



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5970

BIRTH NO.

| | | | | | | | |
|--|-------------------------|---|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
JIMMIE C. DEAN | | | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 9, 1969 12:45 P.M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
UNION MEMORIAL HOSPITAL | | | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 9, 1969 12:45 P.M. | | | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 9-09 | | | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 6. SEX
Male | 7. RACE
Negro | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER
1323 Greenmount Avenue | | | |
| 9. DATE OF BIRTH
2-7-1938 | | 10. AGE (In years lost birthday) 31 | | 11. BIRTHPLACE (State or foreign country)
Fairmount, N. C. | | | |
| 12. CITIZEN OF
U.S.A. | | 13. FATHER'S NAME
Mack Dean | | | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | |
| 15. MOTHER'S MAIDEN NAME
Annie Woodley | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
yes 14 Sep 61 - 9 Mar 63 | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT Mack Dean ADDRESS 1323 Greenmount Ave. 21202 | |
| 19. E 814.7
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | CAUSE OF DEATH
Multiple traumatic injuries | | | |
| | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 20A. DATE OF OPERATION | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 21. AUTOPSY? (Yes or No)
yes | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. ? | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ? | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? ? | | | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) ? | | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> ? NOT WHILE AT WORK <input type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR?
Crushed between truck and wall | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Ronald N. Kornblum, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | | | DATE SIGNED
6/9/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-13-1969 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Ceme. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 12 1969 | | 25B. NAME OF REGISTRAR
Robert E. Jansen, M.D. | | 25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213
Marshall W. Jones, Jr. | | | |

6/16/69 - Pedestrian, tried to
stop truck from drifting -
crushed between truck
& wall.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|--|-----------------------------------|--|--|--|--|--|--|------------------------|----------------------------------|--|
| 69 5971 | | | | | Registered No. 69 5971 | | | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Cahni Whitfield</i> | | | | | 2. DATE AND HOUR OF DEATH
<i>June 6 1969</i> M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>University Hosp. D.O.A.</i> | | | | | A. STATE <i>Maryland</i> B. COUNTY <i>17-03</i> | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<i>851 George St</i> | | | | | | |
| 5. SEX
<i>Male</i> | | 6. RACE
<i>C</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | | 8. DATE OF BIRTH
<i>10-9-1906</i> | | 9. AGE (In years last birthday)
<i>66</i> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Labor</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>North Carolina</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | |
| 13. FATHER'S NAME
<i>Warren Whitfield</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Edna Jenkins</i> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | | 16. SOCIAL SECURITY NO.
<i>216-01-8689</i> | | 17. INFORMANT
<i>Carnie Whitfield</i> | | ADDRESS
<i>Same</i> | | |
| 18. <i>250.9 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) DUE TO
<i>Hypertensive Cardior</i>
<i>Vascular Disease</i>
(B) DUE TO
<i>Diabetes</i>
(C) | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/10</i> 19 <i>67</i> to <i>6/6</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/23/69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<i>W. Garner</i> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>6/10/69</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>W. GARNER</i> | | | | | 23D. ADDRESS
<i>1005 W. Lafayette Ave</i> | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 24B. DATE
<i>6-11-69</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Int. Arden Ctl</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md</i> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>12 1969</i> | | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher, M.D.</i> | | | 25C. FUNERAL DIRECTOR
<i>Gray Wilson & Co. Granty Mc</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 69 5972 | | REG. NO. 69 5972 | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Oscar Wright (Brown. Bradshaw) | | 6-10-69 10:15 p.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE
B. COUNTY | | | |
| Provident Hospital, Inc.
1514 Division Street
Baltimore, Maryland 21217 | | | | Maryland | | 13-01 | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 2433 Linden Avenue | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| Male | | Negro | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9-2-04 | |
| | | | | | | 9. AGE (In years lost birthday) | |
| | | | | | | 64 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Bethlehem Steel Co. | | | | | | South Carolina | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Frank Wright | | | | Julia Mitchell | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | 184-10-5140 | | Mrs. Elenora Wright- Wife | |
| | | | | | | ADDRESS | |
| | | | | | | Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | Carcinoma of stomach with metastasis | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| D | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 13, 1969 to June 10, 1969 that (I) (we) last saw the deceased alive on June 10, 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| M. Rivera M.D. | | | | 6-11-69 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| A. J. RIVERA, M.D. | | | | 2243 Madison Avenue Balto., Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Removal | | 6-14-69 | | Hope Cemetery | | Frogmore, South Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUN 12 1969 | | R. E. J. B. M.D. | | Arlington S. Phillips | | 1727 N. Monroe St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.


| BIRTH NO. | | 69 5973 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | | 69 5973 | |
|---|---------|--|------------------|---|--|--|------------------------------|--|--|
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| Newendon, Dollie B. | | | | 6-8-69 6 A.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | | | |
| 38 University Hospital | | | | Md. | | Balto. | | 19-01 | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | | |
| | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER | | | | | |
| | | | | 218 N. Gilmore St. | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| F | N | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9-4-19 | 49 | Housewife | N.C. | U.S.A. | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Franklin Arthur | | | | Lizzie Swain | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | | | Chas Thomas Newendon | | 218 N. Belmore St. | |
| 18. 200.01 | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | 14 hrs. | |
| (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) | | | | Sepsis | | | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | 4 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | bacteremia | | | | | |
| | | | | (C) Retention of sepsis | | | | 5 mos. | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-1 1969 to 6-8 1969 that (I) (we) last saw the deceased alive on 6-8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| G. M. Dempsey, M.D. | | | | 6-8-69 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| G. M. Dempsey | | | | Univ. Hosp. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 6/12/69 | | Baltimore National Cemetery | | Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JUN 12 1969 | | Robert E. Taylor, M.D. | | William S. Phillips | | 1727 N. Mount St. | | | |

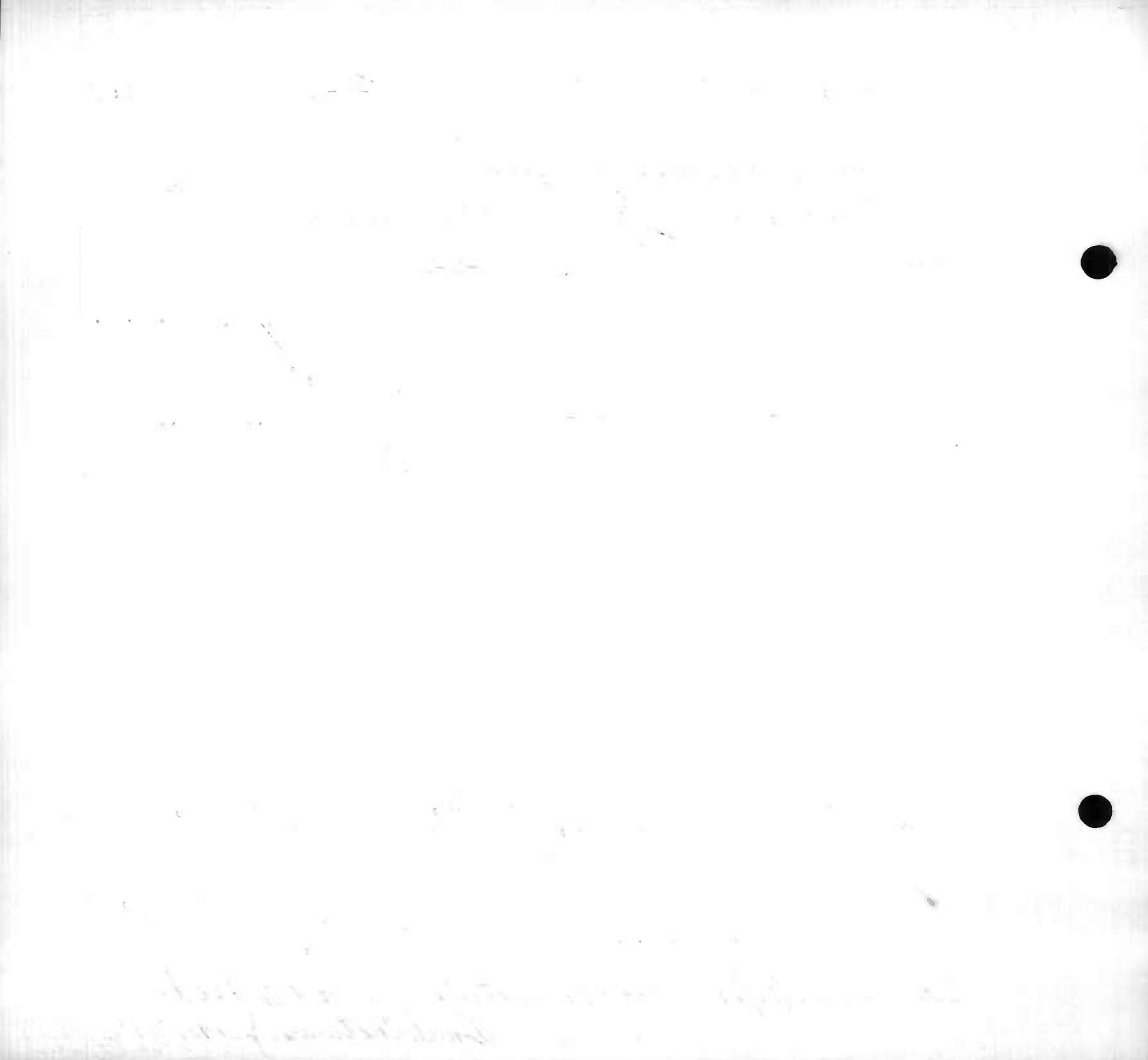
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 5975 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 69 5975 | |
|---|--|---|--|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) WARE, Clifton MNM | | 2. DATE AND HOUR OF DEATH
6-11-69 1:05 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 16-07 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
23 Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX
Male | | | 6. RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Presser | | 10B. KIND OF BUSINESS OR INDUSTRY
Hamburgers mens clothing | | 8. DATE OF BIRTH
7-19-18 | |
| 13. FATHER'S NAME
William Ware | | 14. MOTHER'S MAIDEN NAME
Evelyn Qualls | | 9. AGE (In years last birthday)
50 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 2/8/43 - 2/8/46 | | 16. SOCIAL SECURITY NO.
217-05-9753 | | 11. BIRTHPLACE (State or foreign country)
King William County, Va. | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
Chronic active liver disease with cirrhosis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that XX (this hospital) attended the deceased from June 10, 1969 to June 11, 1969 that X (we) last saw the deceased alive on June 11, 1969 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) XX view the body after death. | | | | | |
| 23A. SIGNATURE

YOUNG E. CHUN, M.D. | | | | 23B. DATE SIGNED
June 11, 1969 | |
| 23C. PHYSICIAN'S NAME (Type)
YOUNG E. CHUN, M.D. | | | | 23D. ADDRESS
3900 Loch Raven Boulevard
Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Buried 6/14/69 | | 24B. DATE
6/14/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Bolton Memorial | |
| 24D. LOCATION (City, town, or county) (State)
Bolton Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Wm. E. Chittman | | 25D. ADDRESS
1701 N. Gullery | |



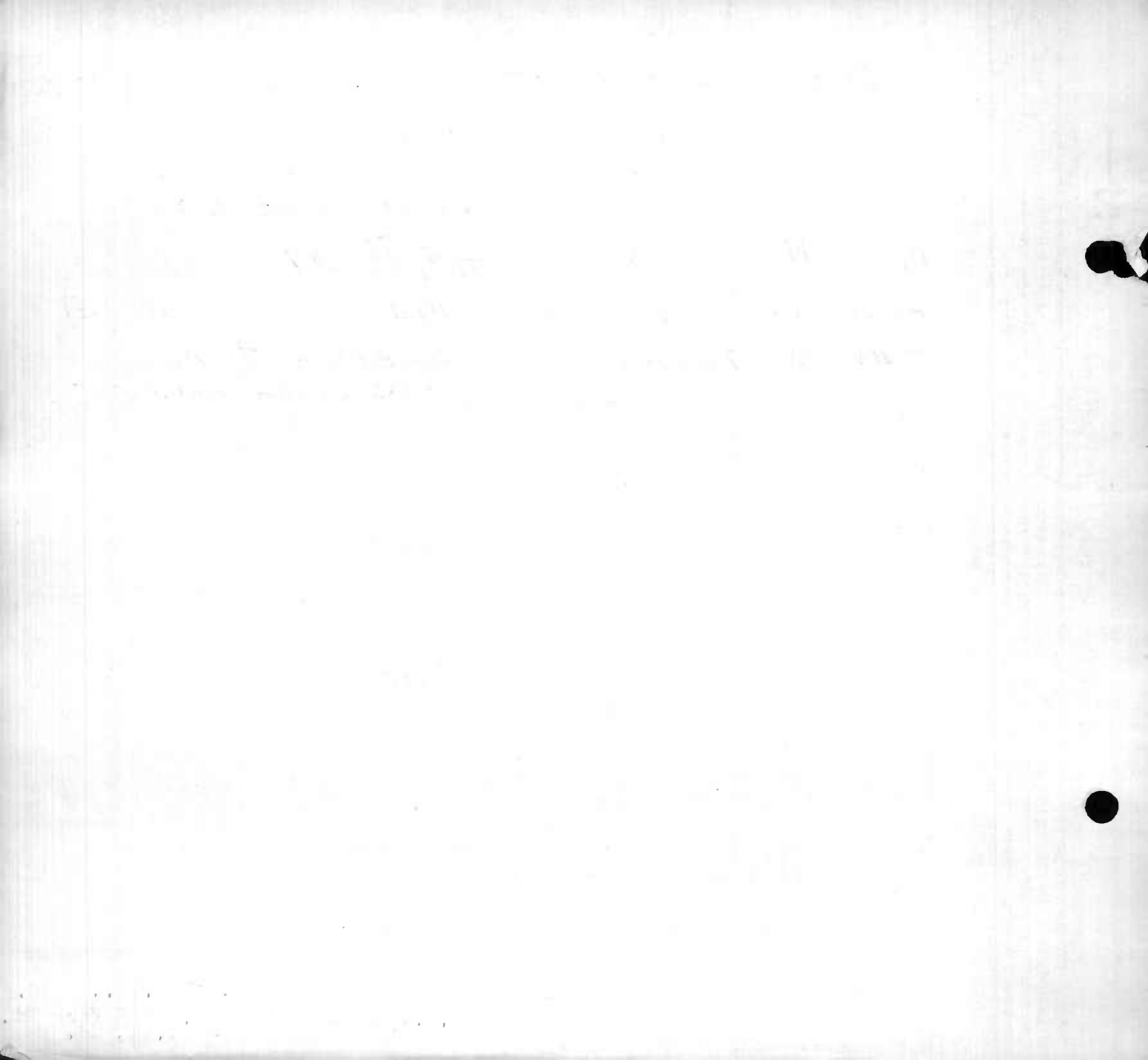
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5976 |
|---|---|---|--|---|
| BIRTH NO. 69 5976 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) ERMA C. ARMACOST | | 2. DATE AND HOUR OF DEATH
6/10/69 6:30 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

Union Memorial Hospital
418 W. Calvert Sts.
Balto. Md. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 27-78 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Union Memorial Hospital | | C. CITY OR TOWN
BALTO. 21212 | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER
612 WOODBURN AVE. | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/15/80 | 9. AGE (In years last birthday)
89 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 11. BIRTHPLACE (State or foreign country)
Md. |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | |
| 13. FATHER'S NAME
JOHN W. INGHAM | | 14. MOTHER'S MAIDEN NAME
SAREPTA J. McCULLOUGH | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-01-9222-B | | 17. INFORMANT ADDRESS
MISS LEONA ARMACOST (SAME) |
| 18. 437.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Bronchopneumonia
(B) Cerebral arteriosclerosis
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days
20+ yrs. |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 6/12/68 to 6/10/69 , that (I) (we) last saw the deceased alive on 6/10/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Clark Beam MD | | 23B. DATE SIGNED
6/10/69 | | |
| 23C. PHYSICIAN'S NAME (Type)
H. V. RIBEIRO MD | | 23D. ADDRESS
Union Memorial Hosp. | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
6/14/69 | 24C. NAME OF CEMETERY or CREMATORY
Parkwood | 24D. LOCATION (City, town, or county) (State)
Parkville, Balto. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | 25B. NAME OF REGISTRAR
Robert E. Jenkins, Md. | 25C. FUNERAL DIRECTOR ADDRESS
H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|------------------|--|-------------------------------|---|--|
| BIRTH NO. | | 69 5977 | | 69 5977 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | Mary M. Wootton | | 2. DATE AND HOUR OF DEATH
6-11-69 2:10 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY | | Md. 27-17 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| The Gundry Sanitarium Inc | | D. STREET ADDRESS (If rural, give location) | | 2 St. Johns Rd. Baltimore, Md | |
| 5. SEX
F | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
4-28-1885 | 9. AGE (In years last birthday)
84 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Social Service | | 10B. KIND OF BUSINESS OR INDUSTRY
State | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Richard Wootton | | 14. MOTHER'S MAIDEN NAME
Elise Contee | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-44-8560 | | 17. INFORMANT
Miss Eleonor White, 100 University Parkway Baltimore, Md | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtemo, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Acute cardiac fibrillation
DUE TO
(B) Arteriosclerotic heart disease
DUE TO
(C) Intestinal virus | | INTERVAL BETWEEN ONSET AND DEATH
several hours
years
24 hrs | |
| 18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerosis general + cerebral | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 11 1968 to June 11 1969, that (I) (we) lost saw the deceased alive on June 10 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Rachel K. Gundry M.D. | | | | 23B. DATE SIGNED
June 11, 1969 | |
| 23C. PHYSICIAN'S NAME (Type)
Rachel K. Gundry | | 23D. ADDRESS
2 N. Wickham Rd - Balto. 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/13/1969 | | 24C. NAME OF CEMETERY or CREMATORY
Druid Ridge | |
| 24D. LOCATION (City, town, or county) (State)
Pikesville, Balto. Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, Jr. | |
| 25C. FUNERAL DIRECTOR
H. W. Jenkins & Sons Co. 4005 York Rd. Balto. 12, Md. | | | | | |

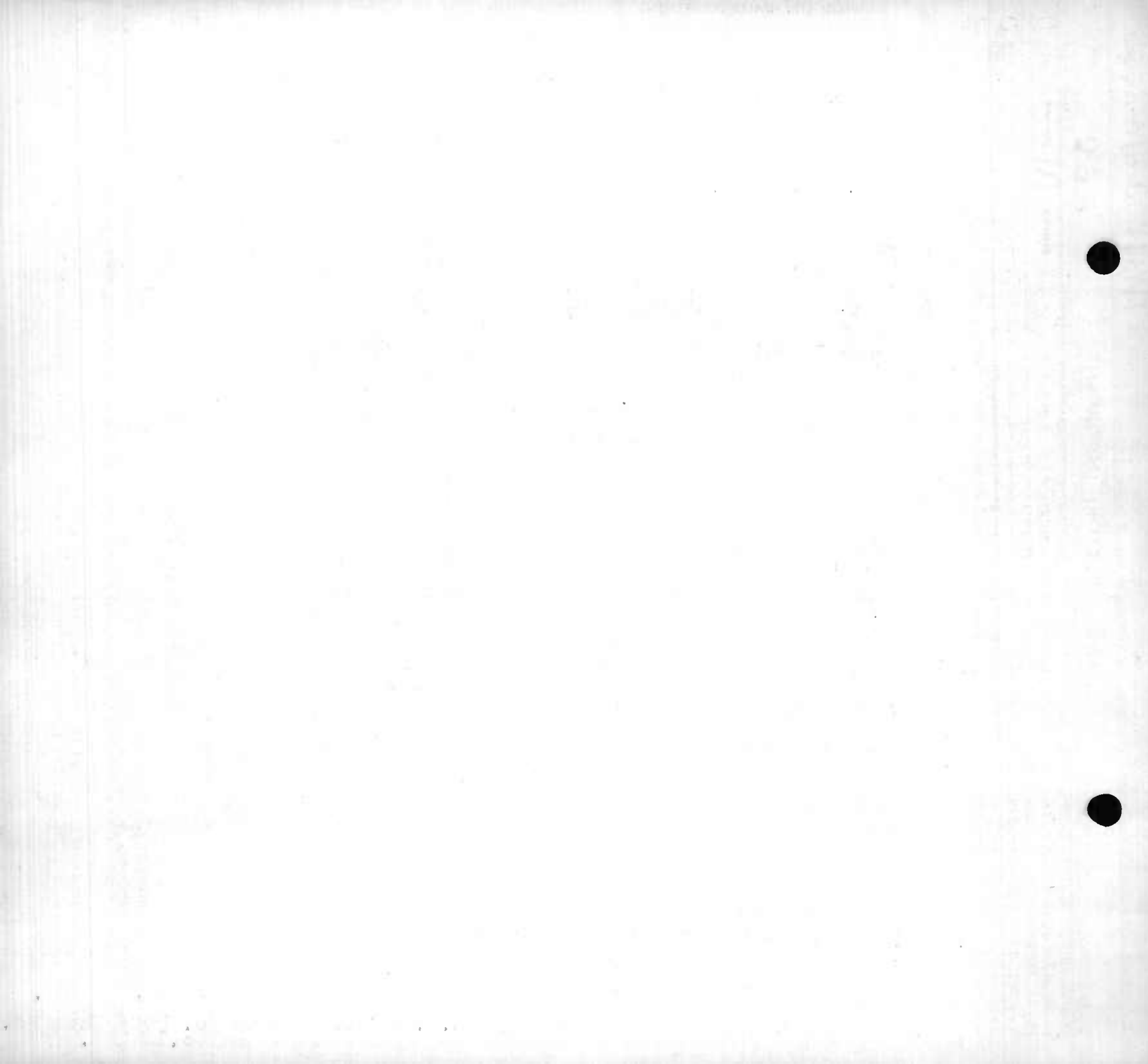
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5978 |
|---|------------------|--|------------------------------------|--|
| 69 5978 | | CERTIFICATE OF DEATH | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) STEVENS, MRS. ELSIE MAY | | 2. DATE AND HOUR OF DEATH
6-11-69 1:45 A M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CHURCH HOME AND HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1530 Gorsuch Ave (18) | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-16-96 | 9. AGE (In years lost birthday) 72 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
MD. |
| 13. FATHER'S NAME
JAMES KEARNEY | | 14. MOTHER'S MAIDEN NAME
ELSIE SMITH | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
215-22-4769 | | 17. INFORMANT
Grace Montgomery (sister) |
| 18. 712-31
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

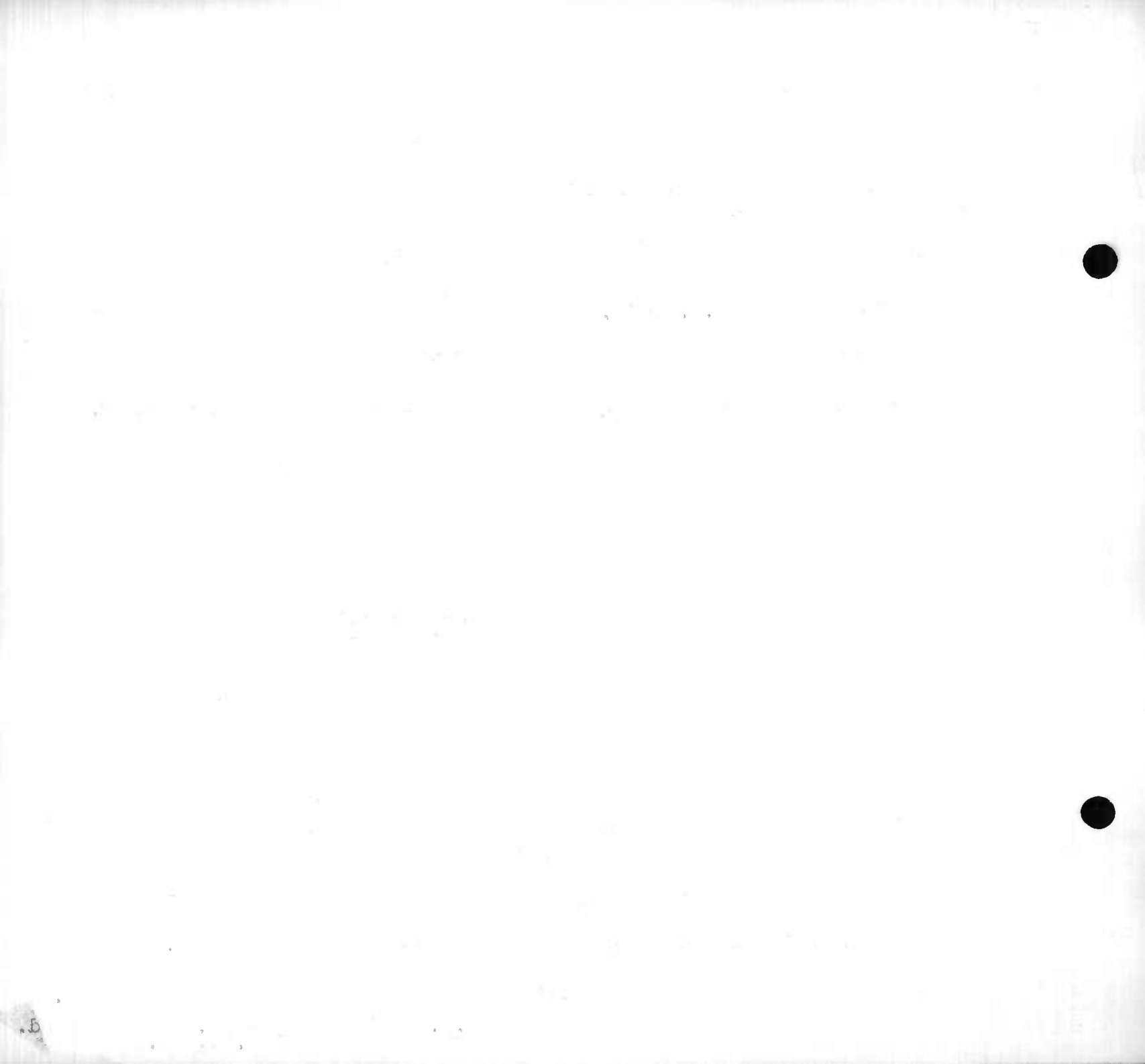
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE Cardiac Arrhythmia due to
DUE TO, OR AS A CONSEQUENCE OF:
atherosclerotic heart disease, Pulmonary
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) edema, Cardiogenic Shock & Rt. hilar mass. | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6-7-1969 to 6-11-1969 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6-11-1969 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | |
| 23A. SIGNATURE
Musabudda | | 23B. DATE SIGNED
6/11/69 | | 23C. PHYSICIAN'S NAME (Type)
MESBAH-UD-DOWLA-MD |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/14/69 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Park |
| 24D. LOCATION
Baltimore County, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | |
| 25B. NAME OF REGISTRAR
Robert E. Galt, M.D. | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 5979 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 69 5979 | |
|---|--------------|---|------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Elwood Elmer Sherrill | | June 10, 1969 1:20 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 9-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE
Md. | | B. COUNTY | |
| US Public Health Service Hospital
3100 Wyman Parkway | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
4060 The Alameda | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/23/15 | 9. AGE (In years last birthday)
53 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired-Office | | 10B. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | | 11. BIRTHPLACE (State or foreign country)
Texas | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Elmer Sherrill | | 14. MOTHER'S MAIDEN NAME
Leona Pemberton | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes
WITT 1938-1947 | | 16. SOCIAL SECURITY NO.
464-05-0665 | | 17. INFORMANT
Records- US PHS Hospital, Balto, Md. | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardio-vascular disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Pulmonary embolism
Bronchopneumonia | | Days
Days | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1 19 69 to June 10 19 69
that (I) (we) last saw the deceased alive on June 10 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Walter F. Oster M.D. | | 23B. DATE SIGNED
6/10/69 | | 23C. PHYSICIAN'S NAME (Type)
Walter F. Oster, Surgeon (R) | |
| 23D. ADDRESS
US PHS Hospital, Balto, Md. 21211 | | 23E. NAME OF REGISTERED FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | 23F. ADDRESS
4905 York Rd. Balto. 12, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/13/69 | | 24C. NAME OF CEMETERY OR CREMATORY
Loudon National | |
| 24D. LOCATION
Baltimore | | 24E. LOCATION
Md. | | 24F. LOCATION
Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | REG. NO. 69 5980 | |
|---|-----------------------------|---|--|---|--|---|--|
| BIRTH NO. | | | | | | <div style="display: flex; justify-content: space-between;"> <div>1. NAME OF DECEASED
(Type or Print) Charles H. Wess</div> <div>2. DATE AND HOUR OF DEATH
6-9-69 6:10 P. M.</div> </div> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
91 Jenkins Memorial Hospital
1000 S. Caton Ave.
Baltimore, Md. 21229 | | | | A. STATE Md.
B. COUNTY 28-54 | | | |
| | | | | C. CITY OR TOWN
Balto. | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
237 E. Medwick Garth (28) | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
8-27-07 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Office | | 10B. KIND OF BUSINESS OR INDUSTRY
Unknown | | 11. BIRTHPLACE (State or foreign country)
Howard County, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Henry J. Wess | | | | 14. MOTHER'S MAIDEN NAME
Anna Mae Mulcahy | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
213-10-0857 | | 17. INFORMANT ADDRESS
Jenkins Memorial Hospital 1000 Caton Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

151.9 I
Cocaine stomach
6 yrs | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION
<input type="checkbox"/> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from <u>April 8 1968</u> to <u>June 7 1968</u> , that (H) (we) last saw the deceased alive on <u>6/8 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
J. Raymond Gladue | | | | 23B. DATE SIGNED
6/9/69 | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type)
J. Raymond Gladue, M.D. | | | | 23D. ADDRESS
1000 S. Caton Avenue, Balto., Md. 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
6-13-69 | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
W. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
W. E. Taylor, M.D., 237 E. Medwick Garth, Baltimore, Md. | | | |

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69 5981 BALTIMORE CITY HEALTH DEPARTMENT

69 5981

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) CHARLES KIRSCHNER | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 9, 1969 1:00 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1029 W. Lombard Street | | 3. DATE PRONOUNCED DEAD
Month Day Year
June 9, 1969 1:00 P. M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
Mar 1, 1895 | | 10. AGE (In years last birthday) 74 75 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Taxi driver | | 14B. KIND OF BUSINESS OR INDUSTRY
Cab | |
| 15. MOTHER'S MAIDEN NAME
Catherine Hausner | | 13. FATHER'S NAME
Kirschner | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW I | | 17. SOCIAL SECURITY NO.
213-05-7679 | |
| 18. INFORMANT
Wilbur Walters | | ADDRESS
2537 Christian Street | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH
Arteriosclerotic cardiovascular disease | |
| 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
6/9/69 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Jun 13, '69 | |
| 24C. NAME of CEMETERY or CREMATORY
Balto. National Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
Robert E. Walters, M.D. | |
| 25C. FUNERAL DIRECTOR
Walters Funeral Home | | ADDRESS
Pratt & Stricker Sts. | |

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VALLEY POLICE

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FUNERAL DIRECTOR: IMPORTANT

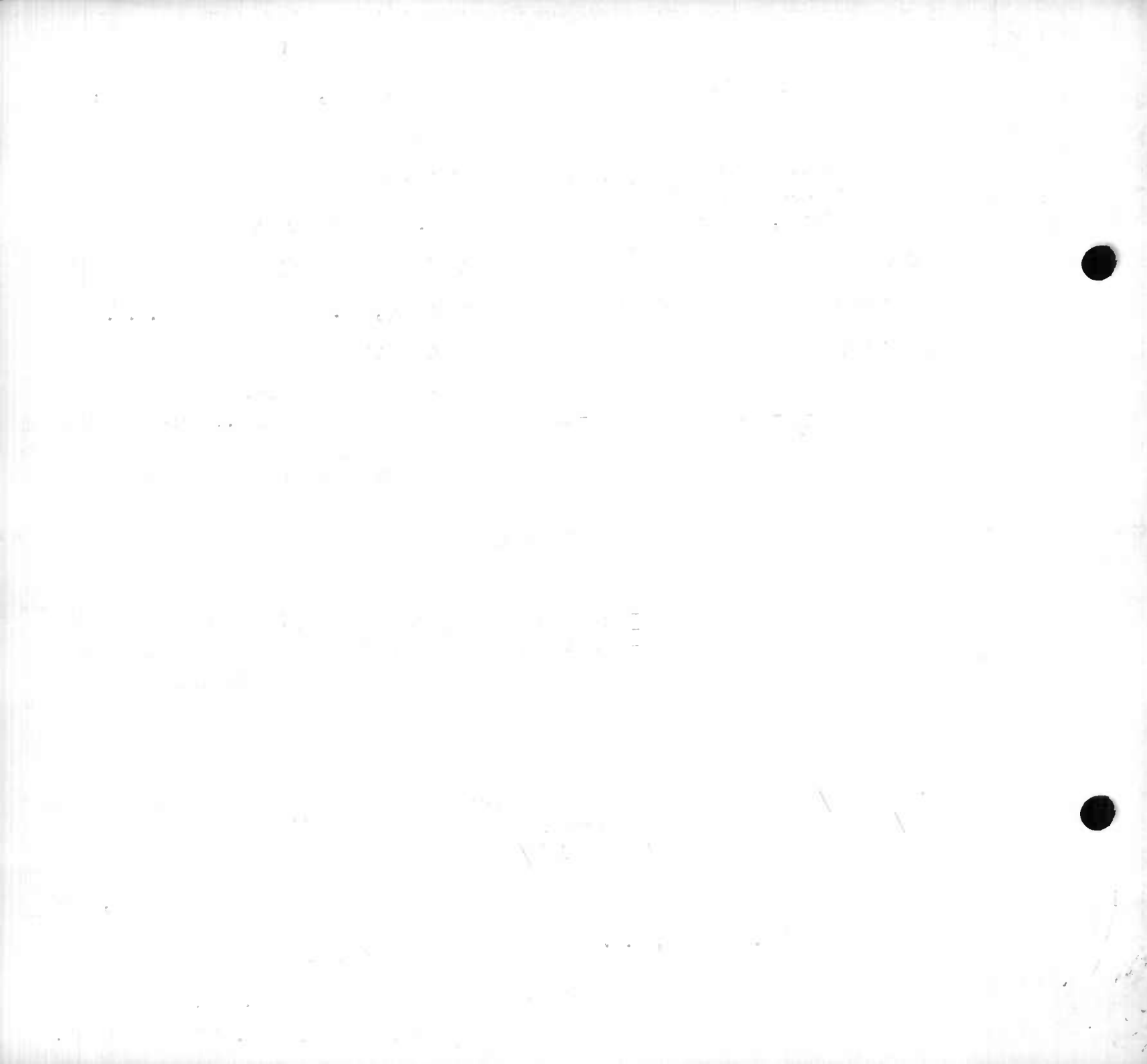
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. |
|---|--------------------------|--|---------------------------------|--|
| 69 5982 | | CERTIFICATE OF DEATH | | |
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <i>McClurg Mary KATHERINE</i> | | June 9 1969 8 ⁰⁵ A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Bon Secours Hospital</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>20-03</i> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | E. STREET AND NUMBER <i>431 S. Pulaski Street</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3-22-01</i> | 9. AGE (In years last birthday) <i>68</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>MILITARY SERVICE</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> |
| 13. FATHER'S NAME <i>John Kilbourne</i> | | 14. MOTHER'S MAIDEN NAME <i>KATE MASLIN</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WWII 1-19-43 7-16-45</i> | | 16. SOCIAL SECURITY NO. <i>212-12-1973</i> | | 17. INFORMANT <i>Chart William J. McClurg, 312 S. Register St. 21231</i> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
<i>Old and recent massive postoperative myocard. infarct</i> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5-31-1969</i> to <i>6-9-1969</i> , that (I) (we) last saw the deceased alive on <i>6-9-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <i>U. Sangkum</i> | | 23B. DATE SIGNED <i>6.9.69</i> | | 23C. PHYSICIAN'S NAME (Type) <i>U. SANGKUM</i> |
| 23D. ADDRESS <i>B 8 H.</i> | | 23E. DEGREE | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>6-12-69</i> | 24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Wash. Blvd. Howard Maryland</i> |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JUN 13 1969</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Harbor, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Howard H. Hubbard 4107 Wilkens Ave. 21229</i> |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5983 | |
|---|-------------------------|---|-----------------------------------|---|--|
| 69 5983 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) TRAVIS, LOUIS ASHBY | | 2. DATE AND HOUR OF DEATH
June 9, 1969 4:00 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland B. COUNTY 23-02 | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
23 Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | E. STREET AND NUMBER
931 S. Charles Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/1/15 | 9. AGE (in years last birthday)
53 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Insulator | | 10B. KIND OF BUSINESS OR INDUSTRY
Electric | | 11. BIRTHPLACE (State or foreign country)
Petersburg, Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Junoir Travis | | 14. MOTHER'S MAIDEN NAME
Maggie Bailey | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 213-10-5546 5/2/45 - 12/20/45 | | 16. SOCIAL SECURITY NO.
512/45 - 12/20/45 | | 17. INFORMANT
VA Hospital Records ADDRESS
3900 Loch Raven Blvd., Balto Md 21218 | |
| 18. CAUSE OF DEATH
6/15/01 | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Obstructive emphysema
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Silicosis
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) 1-Lung infection due to atypical mycobacteria
2-Septicemia due to unknown cause
3-Arteriosclerotic heart disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 years | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE OLD INJURY OCCURRED
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from April 29th 19 69 to June 9th 19 69 that (H) (we) lost saw the deceased alive on June 9th 19 69 and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED
June 10, 1969 | | 23C. PHYSICIAN'S NAME (Type)
RALPH H. TWINING, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/13/69 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore National | |
| 24D. LOCATION
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
John E. Halber, M.D. | |
| 25C. FUNERAL DIRECTOR
JOHN F. 7 DENNY, INC. | | 25D. ADDRESS
715 Light St. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

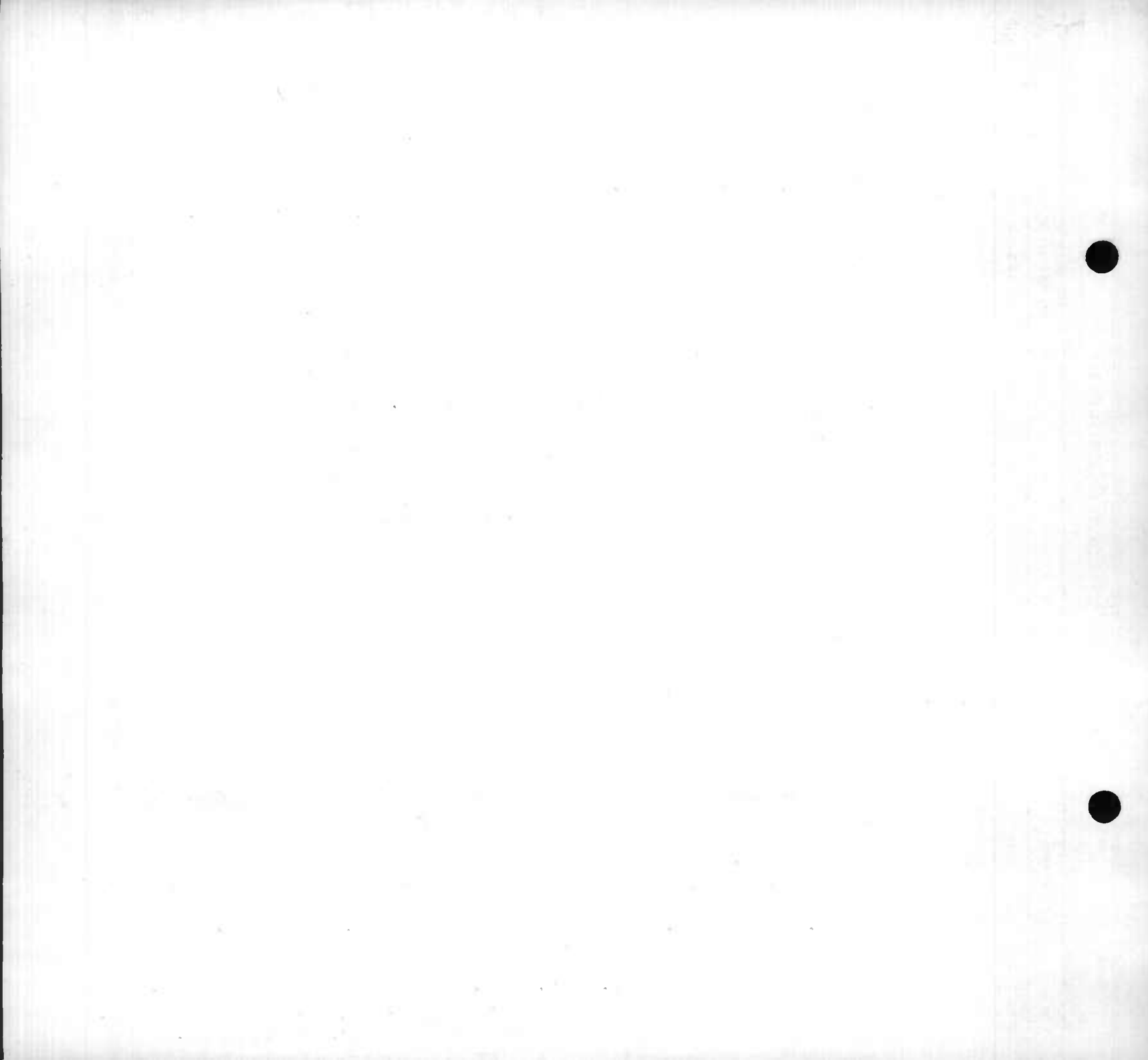
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 69 5984

| | | | | | | | |
|---|------------------|---|-----------------------------|--|---|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) JOSEPH HARRY HUGHES | | 2. DATE AND HOUR OF DEATH
June 10, 1969 | | M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

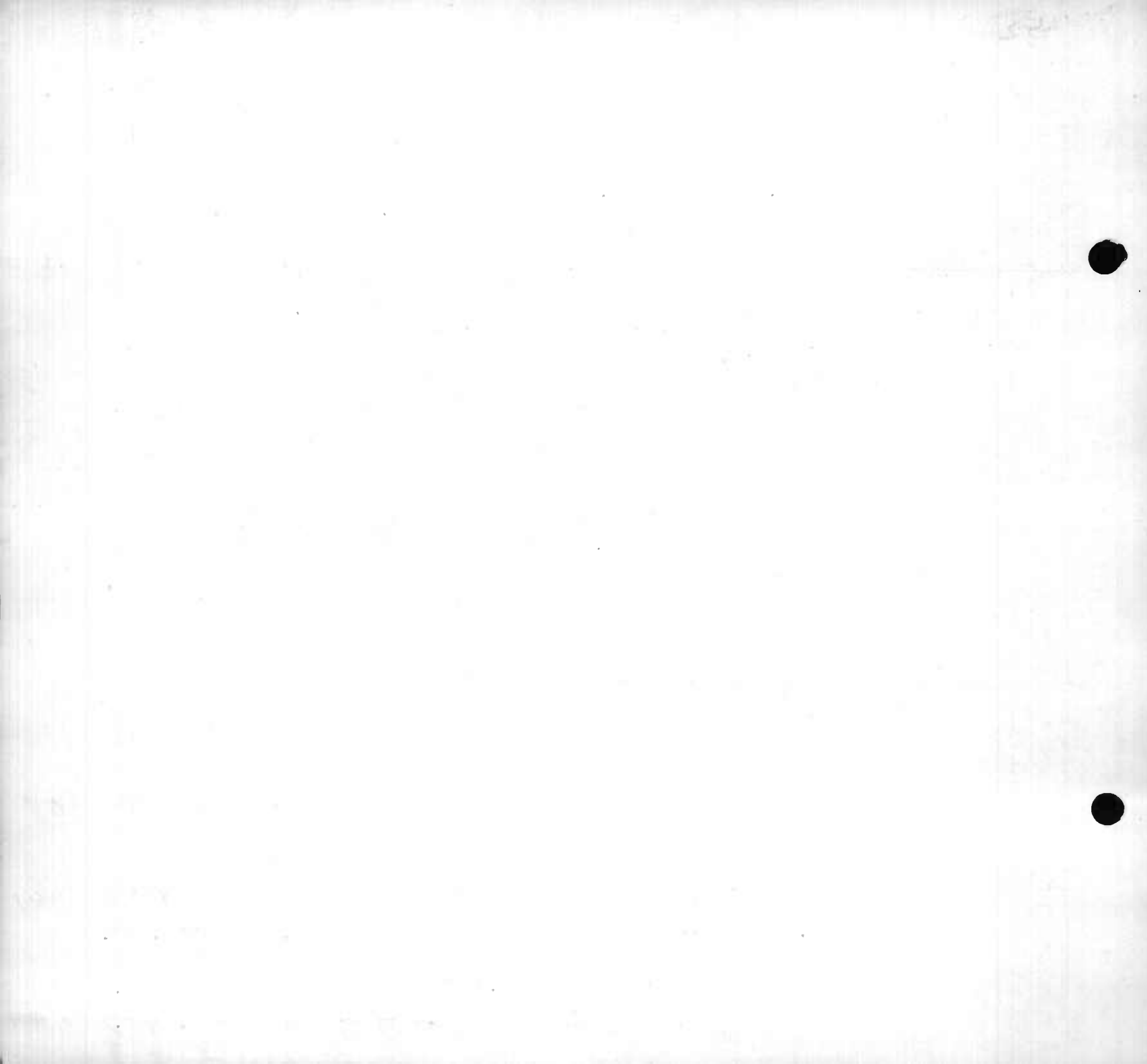
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 2934 E. Monument St. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md., 21205
B. COUNTY 7-01
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2934 E. Monument St. | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/12/24 | 9. AGE (In years lost birthday)
44 | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Guard | | 10B. KIND OF BUSINESS OR INDUSTRY
Globe Security | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Kenneth W. Hughes | | | | 14. MOTHER'S MAIDEN NAME
Gertrude R. Cole | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes 1948 | | 16. SOCIAL SECURITY NO.
217-14-9252 | | 17. INFORMANT ADDRESS
Gertrude Hughes, mother, above | | | |
| 18. 571101
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
Cirrhosis of Liver
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Alcohol Addiction
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year
3 years. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1, 1968 to June 10, 1969, that (I) last saw the deceased alive on March 10, 1969, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Phillip D. Flynn | | | | 23B. DATE SIGNED
6-11-69 | | 23C. PHYSICIAN'S NAME (Type)
Dr. Phillip D. Flynn | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/12/69 | | 24C. NAME of CEMETERY or CREMATORY
Balto. Nat. Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
J. E. Walker, R.D. | | 25C. FUNERAL DIRECTOR
Schlimmer Funeral Home, Inc.
2601 E. Madison St. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5985 |
|--|------------------|--|-----------------------------|---|
| BIRTH NO. | | 69 5985 | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) | | GEORGE HOWARD WILLIAMS | | 2. DATE AND HOUR OF DEATH
June 7, 1969 11:15 p. M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. 21224 B. COUNTY 6-01 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 423 N. Robinson St. | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
423 N. Robinson St. | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/25/05 | 9. AGE (In years last birthday)
64 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bottler | | 10B. KIND OF BUSINESS OR INDUSTRY
National Brewery | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
George E. Williams | | |
| 14. MOTHER'S MAIDEN NAME
Sarah Hipsley | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | |
| 16. SOCIAL SECURITY NO.
220-07-3728 | | 17. INFORMANT
Helen Holthaus Williams, wife, above | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
CARCINOMA PROSTATE
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
WITH LIVER AND LUNG METASTASIS
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 YRS |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 4, 1969 to JUNE 6, 1969, that (I) last saw the deceased alive on JUNE 6, 1969 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Dr. Colen Heinritz | | 23B. DATE SIGNED
JUNE 10, 1969 | | 23C. PHYSICIAN'S NAME (Type)
Dr. Colen Heinritz |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/11/69 | | 24C. NAME OF CEMETERY or CREMATORY
Lake View Mem. Park |
| 24D. LOCATION (City, town, or county) (State)
Carroll County, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | |
| 25B. NAME OF REGISTRAR
J. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Schimmels Funeral Home, Inc. | | |
| 25D. ADDRESS
3331 Brehms Lane | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5986 | |
|---|--|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> 39 5986 69 5986 </div> | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Anna Elizabeth Moore | | 2. DATE AND HOUR OF DEATH
June 11, 1969 10:15 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland B. COUNTY 20-05 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
91 Jenkins Memorial Hospital
1000 Caton Avenue
Baltimore, Maryland 21229 | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
Female | | 6. RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
August 20, 1891 77 | |
| 13. FATHER'S NAME
John Sullivan | | 14. MOTHER'S MAIDEN NAME
Mary Donnelly | | 9. AGE (In years lost birthday)
77 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-32-4980 | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 17. INFORMANT
Jenkins Memorial Hospital | | ADDRESS
1000 Caton Avenue | | | |
| 18. 412.31
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Cachexia | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Chronic Brain Syndrome | | (B) years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) Arteriosclerotic Heart Di | | (D) years | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from April 19 1966 to June 11 1969 , that (H) (we) last saw the deceased alive on June 11 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. Raymond Gladue M.D. | | 23B. DATE SIGNED
6/11/69 | | 23C. PHYSICIAN'S NAME (Type)
J. Raymond Gladue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-14-69 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
John E. Tally, M.D. | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard Funeral Home | |
| 26A. ADDRESS
21229 | | 26B. ADDRESS
21229 | | | |

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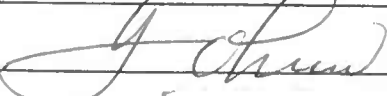
100-100000

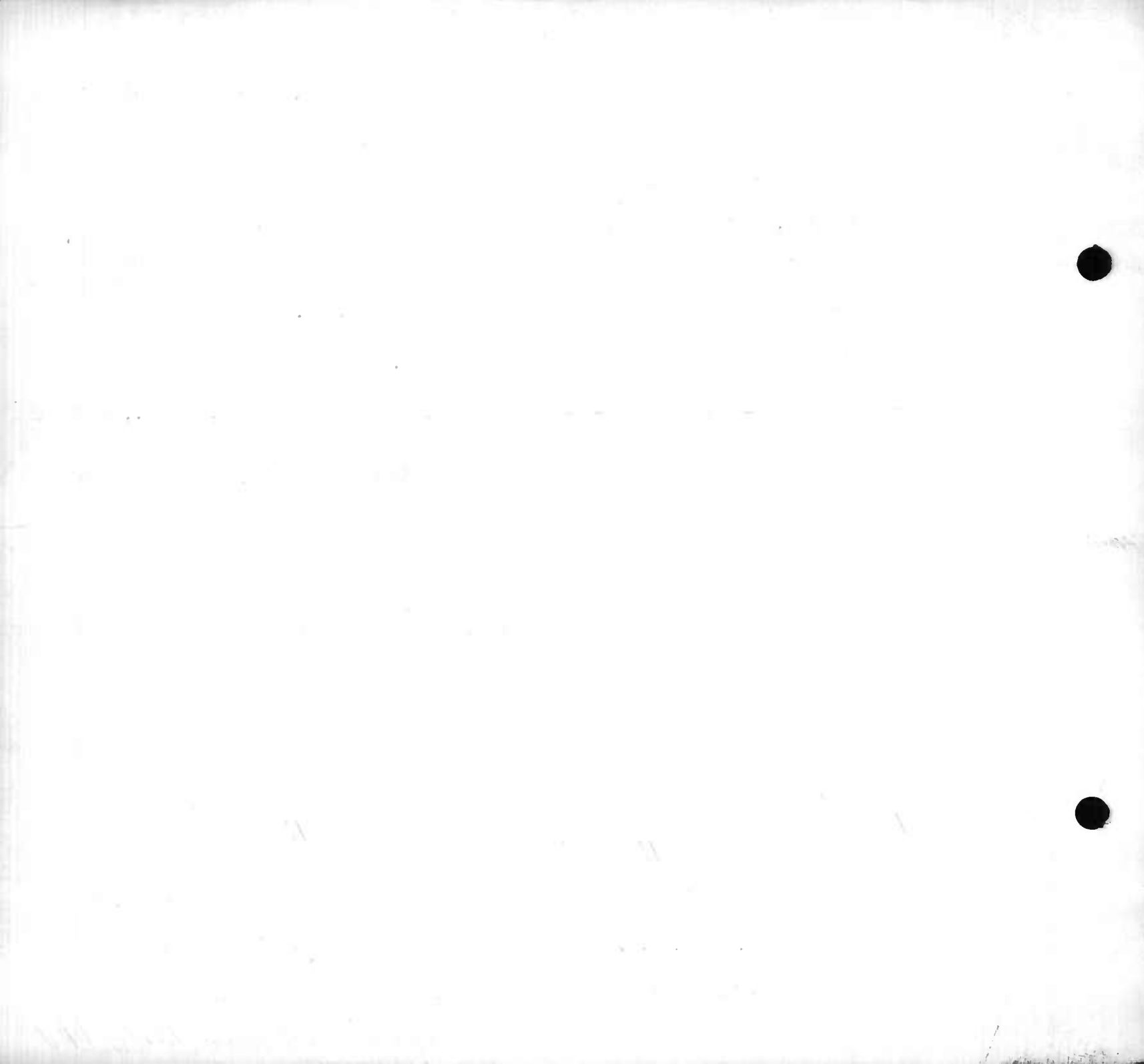
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5987

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5987

| | | | | | |
|---|-------------------------|--|---------------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) RITTASE, Lee Charles | | 2. DATE AND HOUR OF DEATH
June 9, 1969 1:45 A | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 27-65 | | C. CITY OR TOWN Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
23 Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
4301 Grandview Ave | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/31/1888 | 9. AGE (In years last birthday)
80 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lithographer | | 10B. KIND OF BUSINESS OR INDUSTRY
Corrugated Steel | | 11. BIRTHPLACE (State or foreign country)
Adams County, Pa. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
John A Rittase | | 14. MOTHER'S MAIDEN NAME
Leah R. Zellers | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 4/29/18 - 4/15/19 | | 16. SOCIAL SECURITY NO.
298-10-5043A | | 17. INFORMANT VA Hospital Records ADDRESS 3900 Loch Raven Boulevard, Balto., Md 21218 | |
| 18. 28571 CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
II
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Bronchopneumonia
Arteriosclerotic heart disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from June 2nd 19 69 to June 9th 19 69 that (1) (we) last saw the deceased alive on June 9th 19 69 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | 23B. DATE SIGNED
June 9, 1969 | | 23C. PHYSICIAN'S NAME (Type)
YOUNG E. CHUN, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-12-69 | | 24C. NAME of CEMETERY or CREMATORY
Moreland Mem Park | |
| 24D. LOCATION
Baltimore, Maryland 21218 | | 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taber, M.D. | |
| 25C. FUNERAL DIRECTOR
Burke Funeral Home | | 25D. ADDRESS
Baltimore, Md | | 25E. ADDRESS
Baltimore, Md | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 69 5988 | |
|---|--------------------------------|---|--|---|---|
| BIRTH NO. 69 5988 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>William E Fields</u> | | 2. DATE AND HOUR OF DEATH
<u>June 9, 1969</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>90 House in the Pines N. H. Belvedere</u> | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>13-48</u> | | | |
| | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>1327 Weldon Ave.</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>31 Mar 1884</u> | 9. AGE (In years lost birthday)
<u>85</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Mechanic</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>William Fields</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>216 05 1575</u> | | 17. INFORMANT
<u>Miss Helen Fields</u> | |
| | | | | ADDRESS
<u>same</u> | |
| 18. <u>412.3 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

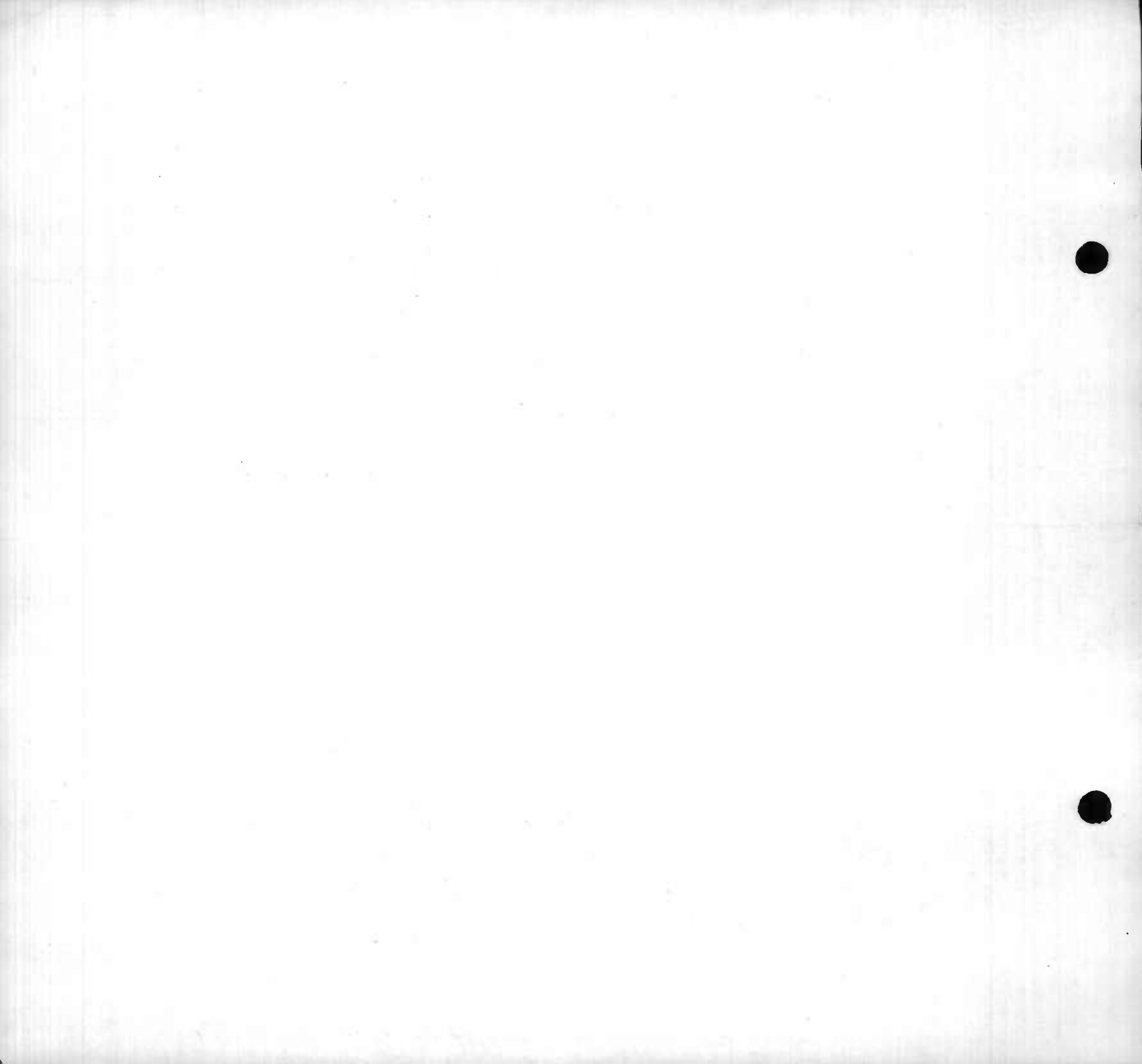
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>(A) IMMEDIATE CAUSE <u>arteriosclerotic C.V.D.</u></u>
DUE TO, OR AS A CONSEQUENCE OF:

<u>(B) _____</u>
DUE TO, OR AS A CONSEQUENCE OF:

<u>(C) _____</u> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A):

<u>II</u> | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 69</u> to <u>June 9 1969</u> , that (I) (we) last saw the deceased alive on <u>June 8 19 69</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Edward L Glassman</u> | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>6/11/69</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Edward L Glassman</u> | | 23D. ADDRESS
<u>4037 Falls Road 21211</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>12 June 69</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>Lorraine Park</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 13 1969</u> | | 25B. NAME OF REGISTRAR
<u>John E. Glassman</u> | | 25C. FUNERAL DIRECTOR
<u>3307 E. 88th St. Funeral Home</u> | |
| | | | | ADDRESS
<u>3631 Falk</u> | |



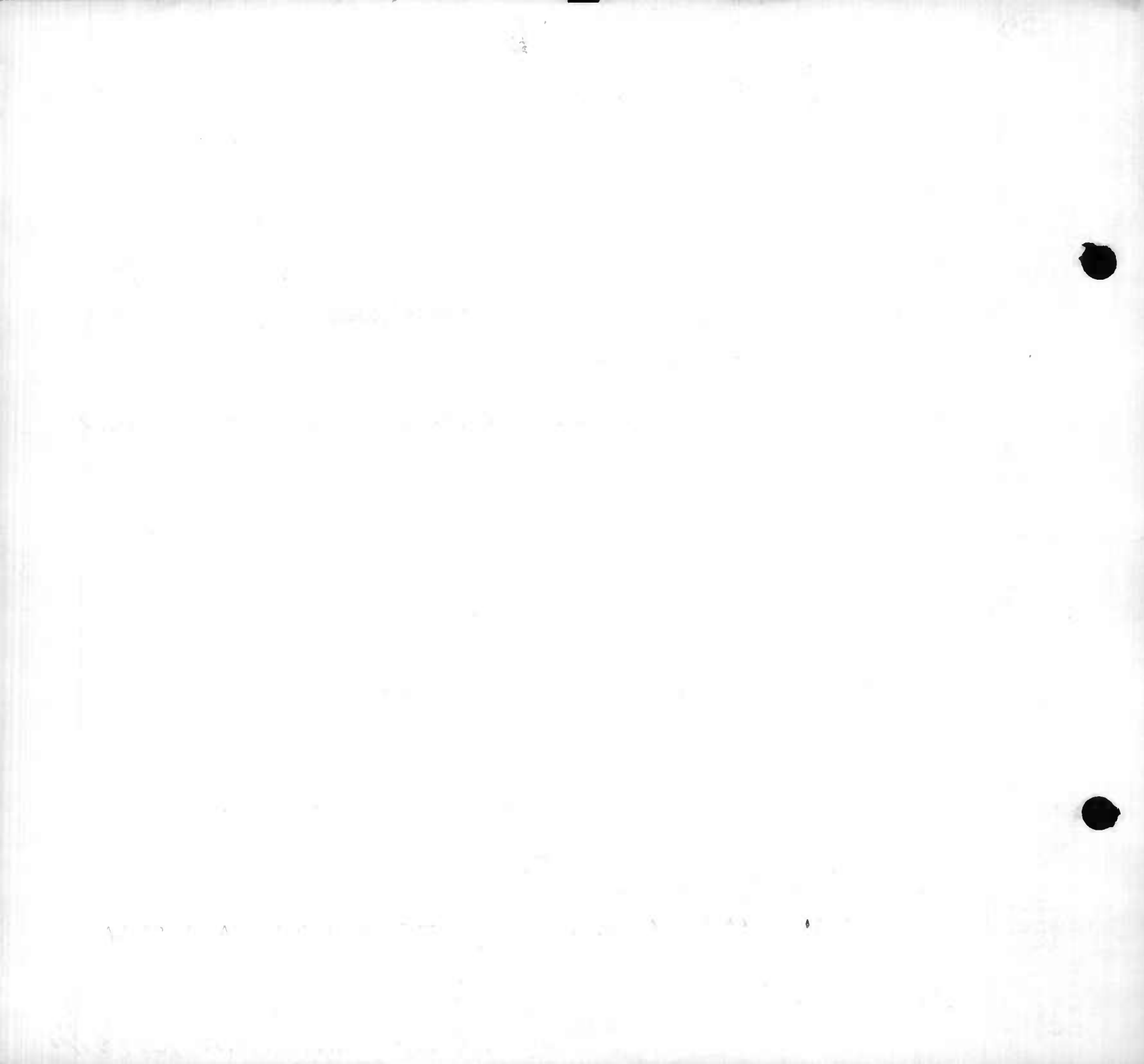
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 5989

| | | | |
|---|--|--|--|
| BIRTH NO. | | 69 5989 | |
| 1. NAME OF DECEASED
(Type or Print) TERENCE P. DONOHUE | | 2. DATE AND HOUR OF DEATH
6-10-69 18:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
UNION MEMORIAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE BALTIMORE B. COUNTY MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
UNION MEMORIAL HOSPITAL | | C. CITY OR TOWN BALTIMORE 21211 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-04-87 9. AGE (in years last birthday) 81 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOTOR MAN | | 10B. KIND OF BUSINESS OR INDUSTRY Belt & Transit | |
| 11. BIRTHPLACE (State or foreign country) IRELAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Patrick Donohue | | 14. MOTHER'S MAIDEN NAME SUSAN MCINTYRE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213 10 1238A | |
| 17. INFORMANT D. Pauline Donohue | | ADDRESS SAME | |
| 18. 600X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
UREMIA
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
CONGESTIVE HEART FAILURE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 5-27-69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BENIGN PROSTATIC HYPERTROPHY | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 5 1969 to JUNE 10 1969 that (I) (we) last saw the deceased alive on JUNE 10 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE R. Salvilla, M.D. | | 23B. DATE SIGNED 6-10-69 | |
| 23C. PHYSICIAN'S NAME (Type) RICARDO SALVILLA, M.D. | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 6-14-69 | |
| 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem | | 24D. LOCATION (City, town, or county) (State) Woodlawn Bt & Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JUN 13 1969 | | 25B. NAME OF REGISTRAR James E. Gable, M.D. | |
| 25C. FUNERAL DIRECTOR Burder Funeral Home | | ADDRESS Bt & Md | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 5990 BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5990 | |
|---|---------------------------|---|--|---|---|
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>ARTHUR A. SMITH</u> | | | 2. DATE AND HOUR OF DEATH
<u>June 11, 1969</u> <u>7:05</u> P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Good Samaritan Hospital</u> | | | C. CITY OR TOWN <u>Baltimore MD 21216</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER
<u>1201 FRANKLINTOWN Rd.</u> | | | | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>NEGROID</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-6-09</u> | 9. AGE (In years last birthday)
<u>59</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME
<u>SAMUEL SMITH</u> | | | 14. MOTHER'S MAIDEN NAME
<u>SYDNEY JACKSON</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>999900019</u> | | 17. INFORMANT
<u>BETTY COLEMAN</u> ADDRESS <u>2722 LONGWOOD</u> | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Metastatic esophageal carcinoma 3mo</u> | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 15</u> 19 <u>69</u> to <u>June 11</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 11</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>David Z. Zuffman MD</u> | | | | 23B. DATE SIGNED
<u>6/11/69</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>6-15-69</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>WESTERN STAR</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>BALTO. MD.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 13 1969</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taber, Md.</u> | | 25C. FUNERAL DIRECTOR
<u>P. R. BAILEY</u> ADDRESS <u>1348 N. Calhoun St.</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5991</u> |
|---|---------------------|---|------------------------------------|---|
| BIRTH NO. <u>69 5991</u> | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Priscilla Reed</u> | | 2. DATE AND HOUR OF DEATH
<u>7:37 EDT 6/11/69</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>17-03</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>University of Maryland Hospital</u> | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER
<u>725 George St</u> | | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/12/02</u> | 9. AGE (In years last birthday)
<u>67</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> |
| 13. FATHER'S NAME
<u>Phil Tyler</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lottie Costman</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>214-20-8065</u> | | 17. INFORMANT
<u>Milford Reed</u> |
| 18. <u>4/12/41</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Arteriosclerotic Cardiovascular Disease</u> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Arteriosclerotic Cardiovascular Disease</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/4</u> 19 <u>67</u> to <u>5/23</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>5/23</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | 23B. DATE SIGNED
<u>6/11/69</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>[Signature]</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>6/16/69</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Arbutus Mem PK</u> |
| 24D. LOCATION
<u>Arbutus Md</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 13 1969</u> | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Charles A. Rice</u> | | |
| 25D. ADDRESS
<u>661 W. Barre St</u> | | | | |

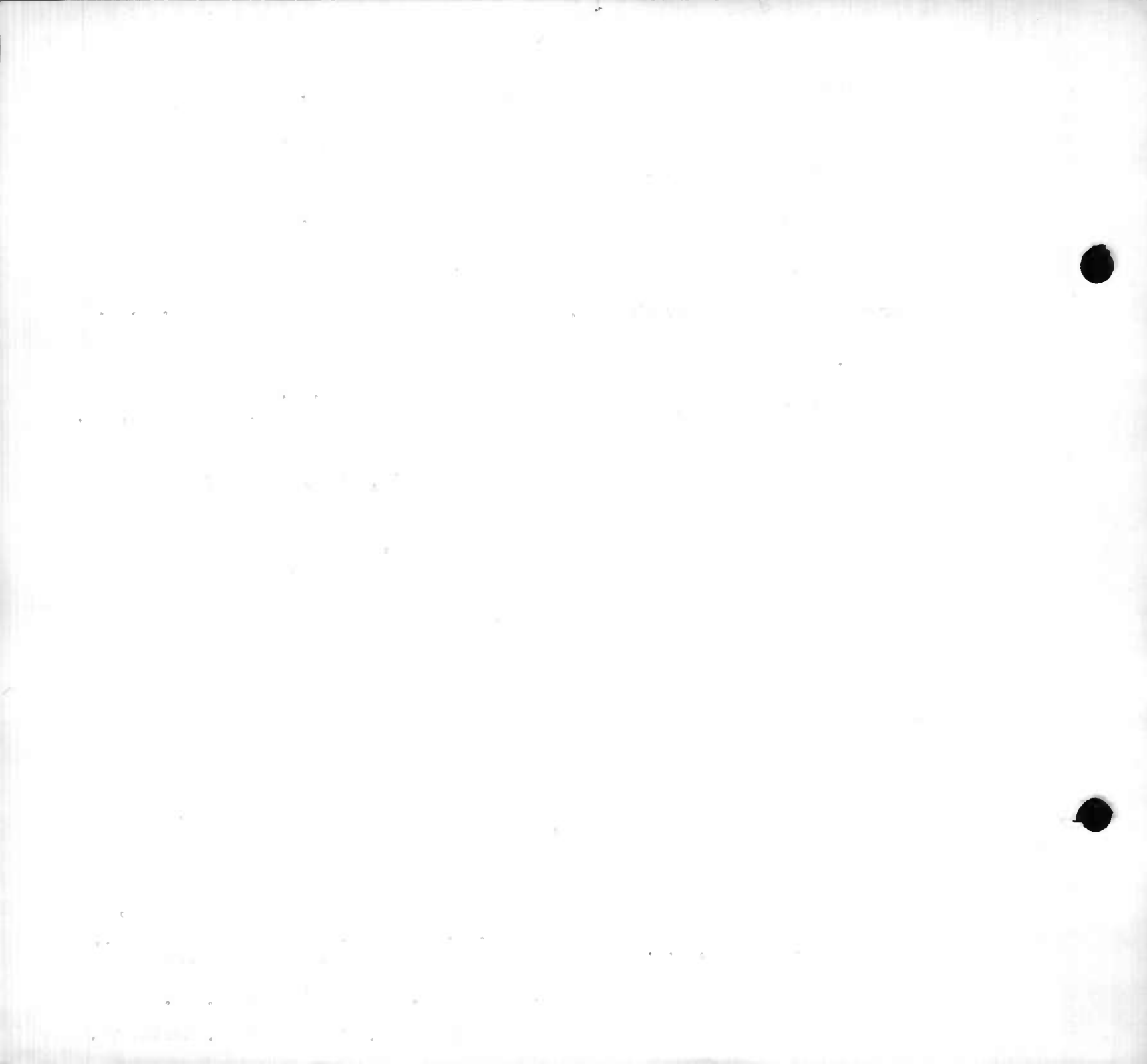


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>69 5992</u> | |
|---|-------------------------|---|--|--|---|
| 69 5992 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>HORSEY, ARTHUR THOMAS</u> | | 2. DATE AND HOUR OF DEATH
<u>June 9, 1969</u> <u>5:00 P.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>23 Veterans Administration Hospital</u>
<u>3900 Loch Raven Boulevard</u>
<u>Baltimore, Maryland 21218</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>3017 Clifton Ave.</u> | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3-14-94</u> | 9. AGE (in years last birthday)
<u>75</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Porter</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>U. Hectch & CO.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>William R. Horsey</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Annie Williams</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>7-15-18 to 7-13-19 212-09-9275</u> | | 17. INFORMANT <u>Records V. A. Hospital</u> ADDRESS <u>3900 Loch Raven Blvd., Baltimore, Md. 21218</u> | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Pneumonia, Right lower lobe</u>
DUE TO, OR AS A CONSEQUENCE OF:
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Advanced Carcinoma, right lower lobe bronchus</u>
DUE TO, OR AS A CONSEQUENCE OF:
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>XI</u> (this hospital) attended the deceased from <u>April 28, 1969</u> to <u>June 9, 1969</u> that <u>XIX</u> (we) last saw the deceased alive on <u>June 9, 1969</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>XII</u> (We) (did) <u>not</u> view the body after death. | | | | | |
| 23A. SIGNATURE
<u>N. Bayadki</u> | | | 23B. DATE SIGNED
<u>June 10, 1969</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>N. BAYADKI, M.D.</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 24B. DATE
<u>6/12/69</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Baltimore, National Cem.</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUN 13 1969</u> | | | 25B. NAME OF REGISTRAR
<u>Robert E. Nutter</u> | | 25C. FUNERAL DIRECTOR
<u>Herbert E. Nutter</u> ADDRESS <u>3035 W. North Ave.</u> |



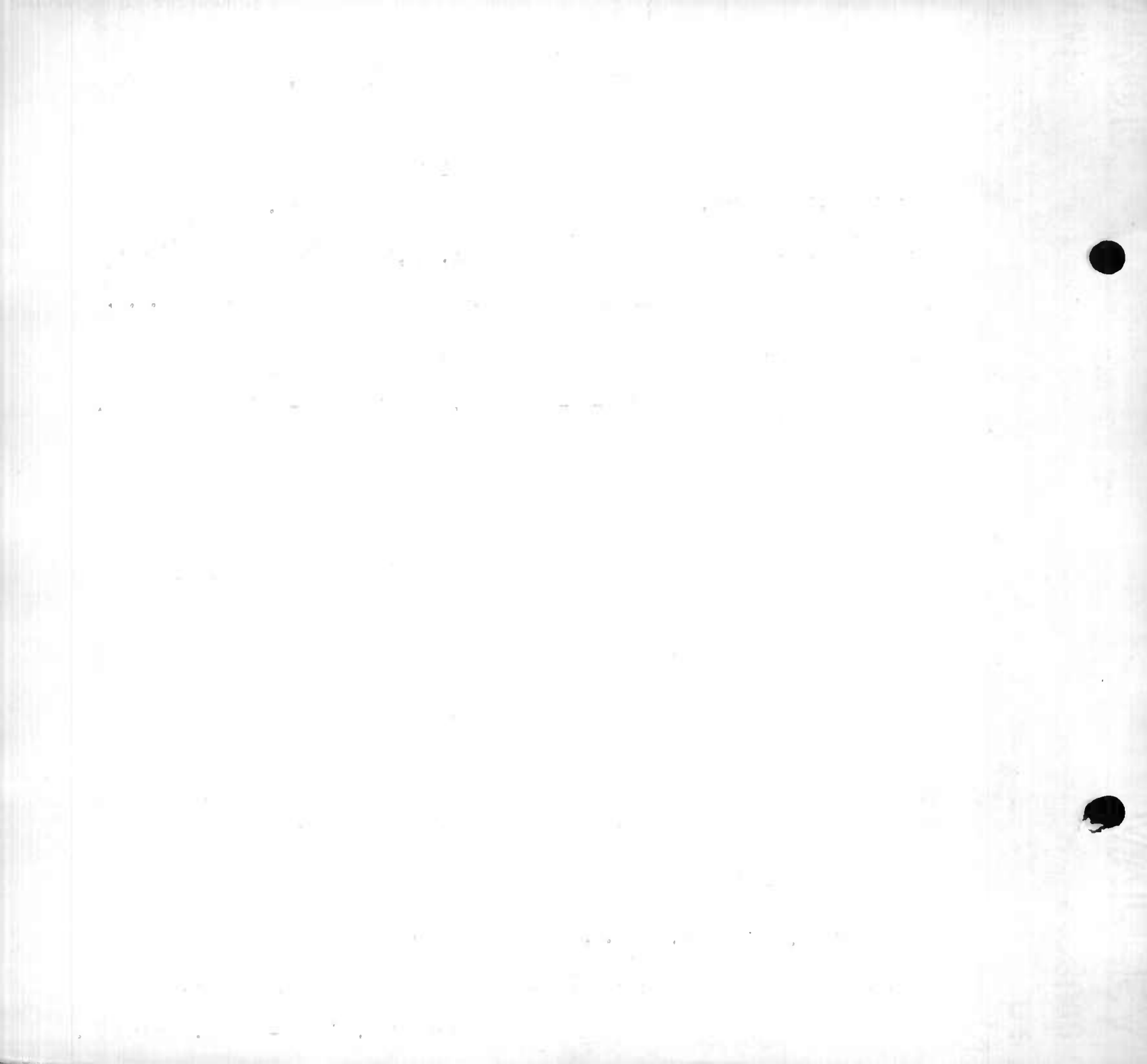
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 5993 CERTIFICATE OF DEATH

REG. NO. **69 5993**

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) John James Carr | | 2. DATE AND HOUR OF DEATH
June 8, 1969 4: A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland B. COUNTY 15-47 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
003201 Windsor Ave. | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Male | | 6. RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Longshoreman | | 10B. KIND OF BUSINESS OR INDUSTRY
Water Front | | 9. AGE (In years last birthday) 72
11. BIRTHPLACE (State or foreign country) Florence South Carolina | |
| 13. FATHER'S NAME
Jerdon Carr | | 14. MOTHER'S MAIDEN NAME
Emma ? ? | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
215-09-7894 | | 17. INFORMANT
Mrs. Ordellia Carr-3201 Windsor Ave. | |
| 18. 412.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Myocardial Infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 Hour | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Myocarditis
DUE TO, OR AS A CONSEQUENCE OF: | | 6 months | |
| | | (C) Hypertensive Cardiovascular disease | | 15 years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from September 10 1960 to June 8 1969 , that (1) (we) last saw the deceased alive on June 8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Samuel R. Owings, Jr., M.D. | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
6/10/1969 | |
| 23C. PHYSICIAN'S NAME (Type)
Samuel R. Owings Jr. M.D. | | 23D. ADDRESS
909 N. Carey | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6/11/1969 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Herbert E. Nutter-3035 W. North Ave. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 5994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

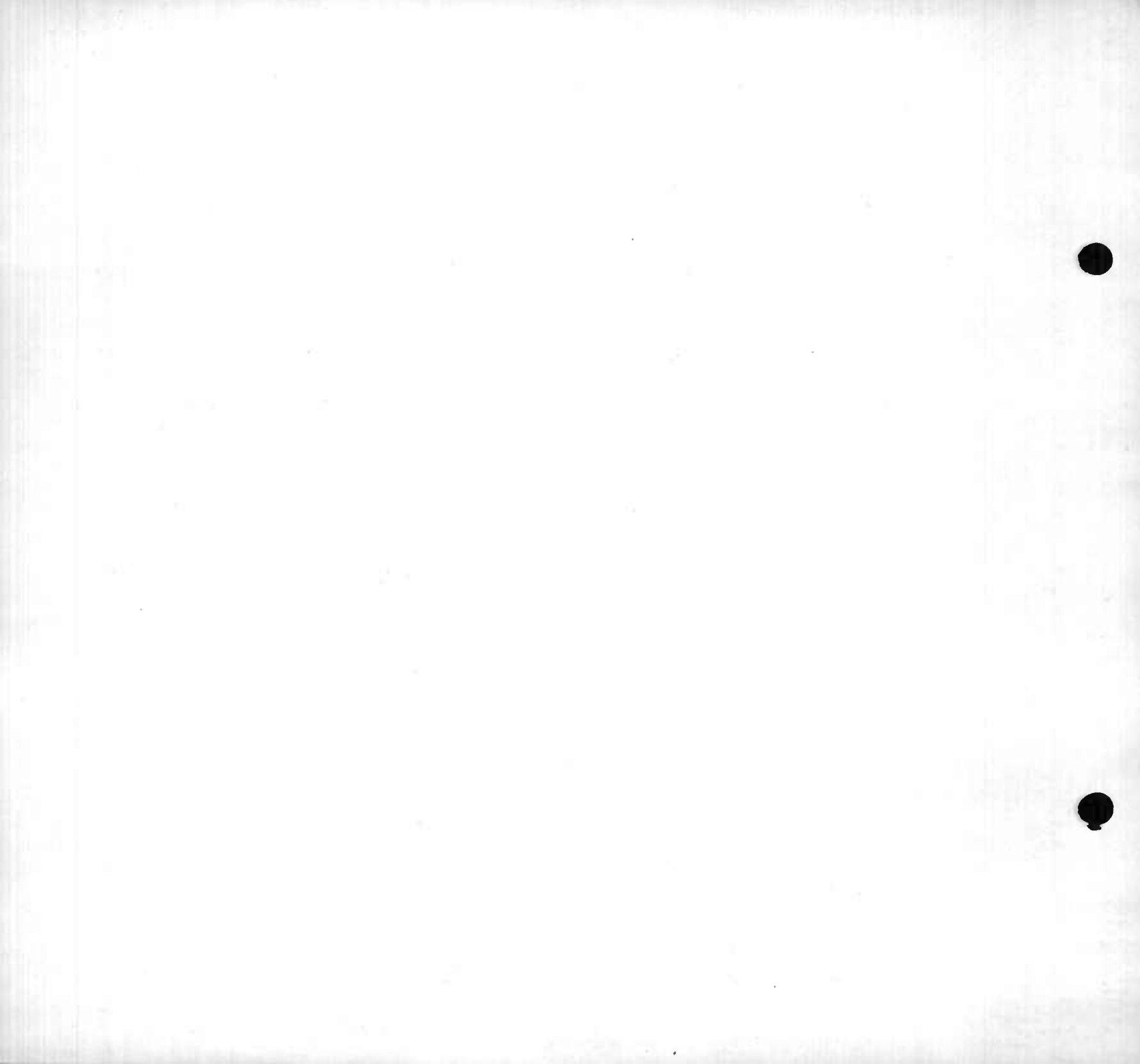
REG. NO. 69 5994

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Louis Louing</u> | | 2. DATE AND HOUR OF DEATH
<u>6/10/69</u> <u>1:15</u> P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>University of Maryland Hospital</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>Male</u> | | 6. RACE <u>N C</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Chauffeur</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Put. family</u> | | 8. DATE OF BIRTH <u>5/8/198</u> 9. AGE (in years last birthday) <u>71</u> | |
| 13. FATHER'S NAME
<u>James Louing</u> | | 14. MOTHER'S MAIDEN NAME
<u>Nannie Ware</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>220-30-0178</u> | | 17. INFORMANT <u>Catherine G. Louing</u> ADDRESS <u>1628 Westwood Ave</u> | |
| 18. <u>43291</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Stenosis of Aorta</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>poor collateral circulation</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>6/7/69</u> 19 <u>69</u> to <u>6</u> 19 <u>69</u> that <u>(X)</u> (we) last saw the deceased alive on <u>19 69</u> and that <u>(X)</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Carol Lee Koski</u> <u>MD</u> | | | | 23B. DATE SIGNED <u>6/10/69</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>CAROL LEE KOSKI</u> <u>MD</u> | | | | 23D. ADDRESS <u>University Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>6-14-69</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore County, Maryland</u> | | 24E. (State) <u>Md</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SUN 13 1969</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Herbert E. Nutter</u> ADDRESS <u>3035 W. North Ave</u> | |

18 98

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|---------|--|------------------|--|---|
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | M. | |
| Francis J. Neuman | | June 9, 1969 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| 37 Mercy Hospital | | Maryland | | 24-01 | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 1427 Cooksire ST. | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| M | W | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12-21-99 | 69 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Stockman | | U.S. Rubber Co. | | Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | | |
| U.S.A. | | Stephen Neuman | | | |
| | | 14. MOTHER'S MAIDEN NAME | | | |
| | | Elizabeth Stockman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 213-10-4079 | | Mrs. Ola Neuman 1427 Cooksire ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | |
| 410.9 I | | Acute Coronary Occlusion | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Arteriosclerotic Cardio Vascular Disease | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-6-69 to 6-9-69, that (I) (we) last saw the deceased alive on 6-9-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Rolando V. Howell, M.D. | | 6-12-69 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 6/13/69 | | Holy Cross Cemetery | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| | | Robert E. Fisher, M.D. | | 1501 East Fort Avenue | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 69 5996 | | REG. NO. 69 5996 | |
|--|---------|--|---|--|--|--|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | JOSEPH BECKMANN | | 6/9/69 1 30 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | |
| | | | | MARYLAND | | 8-43 | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 1909 ELLINWOOD RD | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | |
| M | W | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 3/24/12 | 57 | Longshoemaker | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| | | | BILOXI MISSISSIPPI | | U.S.A | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| THEODORE BECKMAN | | | | ROSA GEORGE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | 215-01-6516 | | 1909 ELLINWOOD ROAD
MRS HELEN BECKMAN | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| 162.11 | | | | | | | |
| <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | | | <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>pulmonary embolism</u></p> <p>(B) <u>post op - heart failure for LUC ca</u></p> <p>(C) <u>in LUC?</u></p> | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 6/4/69 | | LUC ca (lung) | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/22 1969 to 6/9 1969 that (I) (we) last saw the deceased alive on 6/9 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Karl Rosenfeld, M.D. | | | | 6/9/69 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| KARL ROSENFELD, M.D. | | | | SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 6/13/69 | | GARDENS OF FAITH | | TRUMPS RD BALTO MD | |
| 25A. DATE REC'D BY HEALTH DEPT | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUN 13 1969 | | Robert E. Taylor, M.D. | | Cook-ZANNINO | | 7200 Harford Road | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 69 5997 |
|---|--|--|---|--|
| W-650 69 5997 | | | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) WRENN, KITT | | 2. DATE AND HOUR OF DEATH
11 JUNE 1969 8³⁵ A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Sinai Hospital of Baltimore
421 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3780 Columbus Drive 21215 | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/18/1887 | 9. AGE (In years last birthday) 82 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Disable Veteran | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Lunenburg Co. Virginia |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | 13. FATHER'S NAME
Washington Wrenn | | |
| 14. MOTHER'S MAIDEN NAME
Lucy Cross | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Shelby Price | | |
| 18. ADDRESS
3780 Columbus Dr. | | 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Stroke
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
ASHD, Hypertension | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. HOW DID INJURY OCCUR? | | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (this hospital) attended the deceased from 8 JUNE 19 69 to 11 JUNE 19 69 , that (we) lost saw the deceased alive on 11 JUNE 19 69 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death. | | |
| 23A. SIGNATURE
Morris Ostroff, MD | | 23B. DATE SIGNED
11 JUNE 1969 | | 23C. PHYSICIAN'S NAME (Type)
MORRIS Ostroff, MD |
| 23D. ADDRESS
Sinai Hospital of Baltimore | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | |
| 24B. DATE
6-15-69 | | 24C. NAME of CEMETERY or CREMATORY
Calvary Bapt. Ch. Cem | | 24D. LOCATION (City, town, or county) (State)
Lunenburg Co. VA. |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Dyett F.H. |
| 25D. ADDRESS
1701 Laurens St | | | | |

RIGHT

WALL

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) JAMES STITH | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> June 10, 1969 4:10 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LUTHERAN HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 10, 1969 4:10 P. M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 16-03 | | | |
| 6. SEX
Male | 7. RACE
Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN
Baltimore
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH
3-23-1915 | 10. AGE (In years last birthday) 54
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | E. STREET AND NUMBER
1621 Lafayette Avenue | |
| 11. BIRTHPLACE (State or foreign country)
Jarrett, Virginia | | 12. CITIZEN OF
U.S.A. | |
| 13. FATHER'S NAME
James Stith | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Self-employed | |
| 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME
Charity Stith | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 17. SOCIAL SECURITY NO.
218-05-4148 | |
| 18. INFORMANT
Mrs. Shirley Stith | | ADDRESS
1112 Woodyear Street | |
| 19. 150X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of Esophagus
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) Ronald N. Kornblum M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 6/11/69 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
6-14-69 | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland |
| 25A. DATE REG'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
J. E. Taylor, M.D. | 25C. FUNERAL DIRECTOR ADDRESS
MORTON & DYETT F.H. 1701 Laurens Street |

Handwritten signature or initials.

M-224/69

5999

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 5999

BIRTH NO. 68-18571

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
PATRICIA ANN MC CASKILL | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input checked="" type="checkbox"/> June 10, 1969
Hour 6:30 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1707 Linden Avenue | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
June 10, 1969 6:30 A.M. | |
| 6. SEX
female | | 7. RACE
negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 14-01 | |
| 9. DATE OF BIRTH
9-4-1968 | | 10. AGE (In years lost birthday)
9 Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Carlie McCaskill | | 14. MOTHER'S MAIDEN NAME
Carolyn McCaskill | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Infant | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
-0- | |
| 17. INFORMANT
Mr. Carlie McCaskill | | 18. ADDRESS
1707 Linden Avenue | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
SDII (Interstitial Pneumonitis) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
Yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | |
| 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Russell S. Fisher, M.D.
EXAMINER'S NAME (Type)
DATE SIGNED 6/10/69 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-12-69 | |
| 24C. NAME of CEMETERY or CREMATORY
Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
MORTON & DYET | | 25D. ADDRESS
F.H. 1701 Laurens Street | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------------|---|--|--|---|---|---|--|--|
| B-340 69 6000 | | | | | CERTIFICATE OF DEATH | | | | |
| BIRTH NO. | | | | | REG. NO. 69 6000 | | | | |
| 1. NAME OF DECEASED
(Type or Print) BODLEY, Morris | | | | | 2. DATE AND HOUR OF DEATH
6-10-69 | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00
608 North Monroe Street
Baltimore, Maryland | | | | | A. STATE Md. B. COUNTY Balto City | | | | |
| | | | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| E. STREET AND NUMBER
608 North Monroe | | | | | | | | | |
| 5. SEX
MALE | 6. RACE
NEGROID | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2-2-1914 | 9. AGE (In years last birthday)
55 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
CHARLES BODLEY | | | | | 14. MOTHER'S MAIDEN NAME
ANNIE FOOT | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
217058457 | | 17. INFORMANT
Helen Bodley ADDRESS
2468 Seventh Avenue
New York City, N. Y. | | | |
| 18. 1990 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Respiratory failure
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Generalized Carcinomatosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 8 1969 to June 10 1969 , that (I) (we) last saw the deceased alive on June 8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
S. Shorofsky | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
6/11/69 | |
| 23C. PHYSICIAN'S NAME (Type)
S. BOROF-SKY | | | | | 23D. ADDRESS
601 N. Monroe St. Baltimore, MD | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
6-14-69 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Memorial Park | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUN 13 1969 | | | 25B. NAME OF REGISTRAR
Charles E. Baker, MD. | | | 25C. FUNERAL DIRECTOR ADDRESS
MORTON & DYER F.H. 1701 Laurens Street | | | |

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